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Medical Care

in the

Counties of Maryland

Maryland State Planning Commission

April — 1944

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Medical Care in the Counties of Maryland

Report of the

Committee on Medical Care

of the

Maryland State Planning Commission

April—1944

PUBLICATION NO. 40

For sale by the Maryland State Planning Commission

301 Latrobe Hall, The Johns Hopkins University

Baltimore, Maryland

Price 50 cents

MAR 15 1945

Two contrary laws seem to be wrestling with each other nowadays; the one, a law of blood and of death, ever imagining new means of destruction and forcing nations to be constantly ready for the battlefield—the other, a law of peace, work and health, ever evolving new means of delivering man from the scourges which beset him.

The one seeks violent conquests, the other the relief of humanity. The latter places one human life above any victory;—while the former would sacrifice hundreds and thousands of lives . . .

Louis Pasteur,
At the opening of the Pasteur Institute,
November 14, 1883.

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State Department of Health

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Huntington Williams, M. D., *Baltimore City Health Department*

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Victor F. Cullen, M. D., *Acting Chairman*

Joint Committee for the Survey of Medical Care in the Counties of Maryland

State Department of Health:

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Benjamin C. Perry
Walter N. Kirkman

State Department of Public Welfare:

J. Milton Patterson
W. Wallace Lanahan
William L. Galvin

Committee on Medical Care of the Maryland State Planning Commission

Allen W. Freeman — Victor F. Cullen — Maurice C. Pincoffs, *Chairman*

W. Ross Cameron, *Director of Survey*

MARYLAND STATE PLANNING COMMISSION

BALTIMORE, MARYLAND

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THOMAS B. SYMONS
EZRA B. WHITMAN
ABEL WOLMAN
Chairman

I. ALVIN PASAREW
Director

April 15, 1944.

Honorable Herbert R. O'Conor,
Governor of Maryland,
Annapolis, Maryland.

My dear Governor O'Conor:

I take pleasure in transmitting herewith, for your consideration, the report of the State Planning Commission's Committee on Medical Care. In the report the findings and recommendation for a long-term medical care program for the State's indigent and medically indigent are summarized.

The Committee has devoted itself during the past three years to the task of assembling data and information in the field. Upon the basis of these findings it has developed a State program embracing medical care services for the indigent and medically indigent for the counties. This program has the acceptance of the various public agencies and professional and lay groups associated with the administration of medical care services throughout the State.

This report represents the first stage of the Committee's planning program. Plans have been formulated to study and recommend a program for Baltimore City, which represents a far more complex problem. The Committee will also continue to serve the Commission as its advisory body on all phases of medical care plan and program.

Your attention is particularly called to the recommendations of the Committee suggesting "important and basic extension of the duties of the State Department of Health", since these should obtain your early attention so as to bring about effective implementation of the recommendations.

The Commission takes pleasure in acknowledging its indebtedness to the members of the Committee who gave so unstintingly of time and effort, and to various public and private groups which contributed so generously to this work.

The Commission deeply appreciates your support and full cooperation in the development of this program.

Respectfully yours,

Abel Wolman

ABEL WOLMAN, *Chairman*

MARYLAND STATE PLANNING COMMISSION

COMMITTEE ON MEDICAL CARE

BALTIMORE, MARYLAND

527 Bressler Building
University of Maryland
April 10, 1944

Abel Wolman, Dr. Eng., Chairman,
Maryland State Planning Commission
Baltimore, Maryland

Dear Dr. Wolman:

I have the honor to transmit herewith the report of the Committee on Medical Care recording the findings of its survey of medical care in the counties of Maryland and its initial recommendations.

The Committee's work to date has strengthened our belief in the soundness of the original concept of the Committee as a continuing instrument for study of the medical care problems of the State. The obvious next concern of the Committee is the medical care problems of Baltimore City, as well as the many post-war projects affecting the State's responsibilities for health and medical care which doubtless will come to the Committee for study and comment.

It should be recognized that the initial recommendations included herein propose an important and basic extension of the duties of the State Department of Health. Its functions traditionally have been limited strictly to environmental health matters. We propose extending its scope to include responsibility for personal health service to the indigent and medically indigent.

While we propose the use of governmental funds only for the care of the indigent and medically indigent, we believe this use, in the manner suggested in the body of this report, will encourage more effective integration of all the State's medical resources (private, voluntary and governmental) and assure more and better health services to all our citizens.

Sincerely yours,

Victor F. Cullen, M. D., *Acting Chairman*

FOREWORD

The Medical and Chirurgical Faculty of Maryland, aware of many deficiencies in the present status of medical care[1] in this State and of the absence, in Maryland, of an official warrant for any group to evolve a coordinated program of medical care, proposed on August 23, 1939, in an open letter[2] to the Chairman of the Maryland State Planning Commission that a standing committee of the Commission be formed continuously to survey the problems of medical care for the citizens of this State. It was suggested that this Committee should formulate, from time to time, recommendations for the extension and better utilization of existing medical facilities, and for the development of such new facilities as may be required. The Faculty recommended that this Committee be composed of representatives from all agencies concerned with the various aspects of medical care as well as from the general public.

After conferences with the various agencies in this field, the Maryland State Planning Commission, with the approval of Governor Herbert R. O'Conor, appointed the following persons to serve as a standing committee of the Maryland State Planning Commission, to be named the Committee on Medical Care, and designated Maurice C. Pincoffs, M. D., as its Chairman:

Maurice C. Pincoffs, M.D. *Chairman*
Charles R. Austrian, M.D.
F. V. Beitler, M.D.
T. Roy Brookes
Lucien Brun, D.D.S.
James D. Carr, M.D.
Alan M. Chesney, M.D.
J. Douglas Colman
Victor F. Cullen, M.D.
Louis H. Douglass, M.D.
Allen W. Freeman, M.D.
Harry Greenstein
Miss Helen E. Wright, R. N.
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I. Alvin Pasarew
J. Milton Patterson
Robert H. Riley, M.D.
George H. Preston, M.D.
Henry E. Sigerist, M.D.
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Walter Sondheim
Harvey B. Stone, M.D.
Mrs. Thomas J. Tingley
Ralph E. Truitt, M.D.
Thomas J. S. Waxter
Huntington Williams, M.D.
C. E. Wise, Jr.
Samuel Wolman, M.D.

The Committee on Medical Care held its first meeting on January 23, 1940. At this meeting, Abel Wolman, Dr. Eng., Chairman of the Maryland State Planning Commission, charged the Committee with the task of determining the existing defects, if any, in our present private and public facilities for medical care. If deficiencies were found, the Committee was expected to determine and evaluate their amount and character. Furthermore, he requested that the Committee be prepared to suggest necessary corrective measures, to indicate what costs would be involved in such a program of correction, at what rate such changes might be introduced, and the most logical source of funds.

The following Executive Committee was appointed and authorized to act for the General Committee:

Maurice C. Pincoffs, M.D. *Chairman*
J. Douglas Colman
Victor F. Cullen, M.D.
Allen W. Freeman, M.D.
Harry Greenstein
Winford H. Smith, M.D.
C. E. Wise, Jr.

Activities of the Executive Committee

During the first year the Executive Committee met weekly, and thereafter, at less frequent intervals. Members of the General Committee were called from time to time to assist in special studies.

The Executive Committee reviewed at length the status of medical and hospital care in the counties of Maryland. A summary of their deliberations was presented to the Maryland State Planning Commission on October 1, 1940. This report emphasized the need for more detailed and comprehensive information and recommended that a field survey be undertaken.

Appointment of the Joint Committee

The Maryland State Planning Commission approved the recommendation that a field survey be made, and formed a special committee, known as the Joint Committee, for the purpose of securing funds for this study. The Joint Committee included representatives of the Committee on Medical Care, the State Department of Health and the State Department of Welfare. The expenses of the survey were financed by appropriations from these two Departments. The members of the Joint Committee were:

Allen W. Freeman, M.D. *Chairman*
Victor F. Cullen, M.D.
Maurice C. Pincoffs, M.D.
Robert H. Riley, M.D.
Benjamin C. Perry, M.D.
Walter N. Kirkman
J. Milton Patterson
W. Wallace Lanahan
William L. Galvin

Survey Plans with Subsequent Modifications

On February 1, 1941, the office and field staff was organized with W. Ross Cameron, M.D., in charge. Dr. Cameron was assigned by the State Department of Health to act as Director of the Survey. It was planned that the

[1] As a rule, "Medical Care" is used throughout this report in an inclusive sense to cover the services rendered by *all* agencies engaged in safeguarding and improving the health of the people.
[2] See Appendix.

work would extend over a period of approximately 15 months, including about 12 for the field survey and 3 for the preparation of the report.

About July 1, 1941, world conditions were such that war seemed imminent. Since several of the Committee and its staff were expecting to be called into active service momentarily, it was decided to modify the program. For example, instead of attempting to interview all physicians in the counties of Maryland, representative groups were selected in three sections of the State.

On September 15, 1941, Dr. Cameron was called into active duty with the U. S. Public Health Service. Work in the field was discontinued and, unfortunately, it was necessary to abandon several important phases of the survey.

Due to the exigencies of war, it was necessary to make important changes not only in the field staff, but in the membership of the committees. On April 1, 1942, Dr. Pincoffs, the Chairman, who devoted many invaluable hours to the work of the Committee, volunteered for active service with the U. S. Army Medical Corps and is now overseas. On July 1, 1942, Allen W. Freeman, M.D., who first served as Chairman of the Joint Committee and later replaced Dr. Pincoffs as Chairman of the Executive Committee, retired from active participation due to illness.

Victor F. Cullen, M.D., was elected to replace Dr. Freeman as the Chairman of the Executive Committee and Charles R. Austrian, M.D., president-elect of the Medical and Chirurgical Faculty of Maryland, was elected to replace Dr. Pincoffs on the Executive Committee.

Scope of Report

In response to a request of the Maryland State Planning Commission that a summary of its work from the date of appointment to the present be made available, the Committee on Medical Care presented an initial report of its findings and recommendations[1].

It has been indicated that, due to conditions beyond the control of the Committee, the field survey and report are incomplete. It is believed, however, that the data accumulated in the field, together with the considered opinions of the Committee, justify adoption of the recommendations for reorganizing and strengthening the medical care structure in the counties of Maryland.

Since changes in the field of medical care have been occurring rapidly, recommendations based on conditions at the time of the survey may not all be applicable on the date of publication. The Committee is of the opinion, however, that, in general, these recommendations are basic and, if conditions are comparable at the termination of hostilities, they should be adopted as soon as funds and manpower are available.

[1]Initial Report of Committee on Medical Care, Maryland State Planning Commission, Publication 38, March, 1943.

Relationship of Survey to Baltimore City

While the Committee on Medical Care was aware that there were serious problems in medical care in the City of Baltimore, it seemed obvious to it that facilities available, particularly the hospitals and clinics, were more adequate than those in the counties and, therefore, that the problem pressed less urgently for solution. For this reason, as well as the magnitude of the task, the scope of the survey was limited strictly to the counties of Maryland. The Committee believes now that the medical care problems of the City of Baltimore should be studied as soon as arrangements can be effected.

Additional Activities of Committee

In addition to the activities outlined in this report, the members of the Committee, both individually and collectively, served as consultants to consider a variety of State-wide medical care problems which were presented for immediate solution. These included the extension of the laboratory services of the State Department of Health, the need to replace almshouses by chronic disease hospitals and the plans for the construction of general hospitals to meet acutely increased demands. In addition, information on the distribution of physicians was provided the Procurement and Assignment Service and data on other aspects of the general problem of medical care were made available to other governmental and private agencies. Several of these activities were the subjects of written reports, in other instances the consultations were quite informal.

Suggestions were received from several sources that the Committee extend its activities to include the study of many new problems which were developing as the war progressed. It was decided, however, that the Committee would confine its attention to the tasks to which it had been assigned.

Acknowledgments

The Committee deeply appreciates the valuable assistance given by many departments of the State government, especially the State and County Departments of Health and the State and County Departments of Welfare. A large number of officials in every county of the State, as well as members of the medical, dental, nursing professions and hospital administrators provided much of the material upon which this report is based. The Committee also is indebted to the U. S. Public Health Service for the assistance of Anrhony Ciocco, Ph.D., who helped to assemble much of the information essential to the preparation of this report.

Chapter I

THE FIELD SURVEY

Objectives

On February 1, 1941, a field survey of medical facilities in the counties of Maryland was instituted. The staff consisted of a director, a secretary and occasional assistance from an additional secretary and seven part-time clerks employed by the Works Projects Administration.

Plans for the survey having been outlined, forms were prepared for the collection of data. From February 15 to September 15, the director spent most of his time in the counties of Maryland and reported to the Executive Committee twice each month. During this period the office staff transcribed and tabulated notes received from the field, obtained from the hospitals of Baltimore City and the District of Columbia detailed information on the admission of county patients, and carried on a number of other activities.

The objectives of the survey were as follows:

1. A study of certain characteristics of the population.
2. A description of medical care facilities including:
   (a) The distribution of physicians, nurses, and dentists and types of service rendered by each.
   (b) The function of hospitals, health and welfare departments.
   (c) The activities of other governmental, voluntary and private agencies.
3. Estimates of the number of indigent[1] and medically indigent[2] and procedures followed by such individuals in securing medical care.
4. A study of the health needs with suggestions for securing more effective use of existing agencies either by improving or extending their activities, or by the organization of other services.
5. Estimates of the costs of such a program.

Individuals Interviewed

The following persons were interviewed:

1. The President or Secretary of every County Medical Society.

   To each the objectives of the survey were explained. In addition, the names of all physicians in active practice, their addresses and other details, obtained from the Directory of the American Medical Association, were checked for accuracy. The names and addresses of those not included in the Directory were obtained.

2. All physicians in seven counties, and others selected at random from widely separated areas.

   A total of 88 physicians, or about 20 percent of those in active practice in the counties, were interviewed at length. Subjects discussed included: (a) description of the local medical and hospital facilities, (b) opinions on present provisions for the medical care of the indigent, (c) recommendations for correcting deficiencies, and (d) other pertinent data. A summary of each interview was recorded on a special form and placed on file.

3. The superintendents of the 18 general hospitals.

   With each superintendent the details of organization, operation and maintenance of the hospital were discussed and the buildings and equipment inspected. A summary of all interviews and reports of inspections were recorded on forms prepared for the purpose.

4. The superintendents, or their representatives, in all general hospitals in the City of Baltimore and in the District of Columbia.

   From each was obtained the number of residents of the counties of Maryland admitted during the year 1940, their addresses, pay status and number of days hospitalized.

5. The Director of the State Department of Health and the Chiefs of Bureaus.

   The activities of the State Health Department relating to medical care were discussed in detail and printed reports were received.

6. The 23 county health officers and a roral of 68 public health nurses.

   With each county health officer an inspection was made of the diagnostic and clinical facilities now provided by the department. Opinions of each officer were obtained on the need for and practicability of expanding these facilities. Estimates of costs were secured. Public health nursing and laboratory services also were studied.

7. The Director of the Department of Welfare and members of his staff.

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[1]The *indigent* include only those receiving assistance from a welfare organization.

[2]The *medically indigent* are those who are usually able to pay the costs of minor illnesses but unable to meet expenses in the event of severe or prolonged disabilities.

The methods of classifying applicants for assistance were discussed as well as the State Department of Welfare policies with respect to providing physicians' services and hospitalization for those on relief.

8. The executives of the 23 county welfare departments.

   From each was obtained an outline of the local procedures for securing medical care for those receiving assistance. An attempt was made to obtain an estimate of the type and costs of care thus provided. A summary of each interview was filed.

9. At least one county commissioner in each of seven counties.

   With each official the local provisions for medical care of the indigent were discussed and, wherever possible, a report of expenditures for this purpose was obtained.

10. Many private citizens.

    Opinions on the need for providing medical care for the indigent and medically indigent were obtained from many citizens in all economic levels. Their experiences with various phases of this subject were recited.

In the interest of economy, the reproduction of forms has been omitted.

Chapter II

CHARACTERISTICS OF THE POPULATION

In approaching the survey of medical care, certain characteristics of the population were studied, including the distribution and economic status, as well as the medical care facilities.

Distribution

1. Total

In Table 1, page 4, it will be seen that the total population, according to the U. S. Census taken as of April 1, 1940, was 962,144; Baltimore County with 155,825 had the largest and Calvert County, with 10,484, the smallest population.

2. Color

In Table 1, it also will be noted that the white population totalled 825,776, and the colored 136,368; Baltimore County had the largest and Calvert the smallest white population with 145,295 and 5,604, respectively; and while Anne Arundel had 17,841 colored persons, there were only 5 in Garrett County.

In Table 2, page 4, it will be observed that in Garrett County the white population comprised 99.9 percent of the total and in Calvert County the white population was 52.1 percent of the total.

3. Density

The population density, the number of persons per square mile in rural areas, has been tabulated in Table 3, page 4, the land areas in square miles having been obtained from the Maryland Geological Survey. It will be noted that the number of persons per square miles varied from 256.5 in Baltimore to 33.1 in Garrett County.

4. Urban and Rural Residents

The proportion of families residing on farms in the counties of Maryland according to the U. S. Census of 1940, has been tabulated in Table 4, page 4. It will be seen that the percentage of families residing on farms ranged from 6 in Allegany ro 61 in Charles County.

5. Percent Increase or Decrease

In reviewing the past and considering the probable future trends in population, the total for each county was tabulated for the years 1790[1] and 1940. These data are reproduced in Table 5, page 6.

In Table 6, page 6, the percent increase or decrease is shown in the total population of each county since the date of establishment. It will be seen that, during the period under review, the population of Allegany County increased by 1,708.5 percent; in 18 other counties the *increases* varied from 512.7 percent in Baltimore to as low as 4.9 in Kent County; in St. Mary's, Queen Anne's and Charles counties *decreases* in population of 5.9, 6.4 and 14.6 percent were recorded.

Economic Status

1. Income Tax Returns

The income tax returns per 1,000 population for the counties of Maryland, as reported by the U. S. Department of Commerce for the year 1938, will be found in Table 7, page 6. The returns varied from 129 per 1,000 population in Montgomery to 6 per 1,000 in St. Mary's and Somerset counties.

2. Recipients of Relief

In Table 8, page 6, the total households in each county receiving assistance from county welfare departments in 1940, together with the number per 1,000 population have been tabulated. In Baltimore County 6.7 households per 1,000 population were recipients of relief, and the proportion increased to 30.4 per 1,000 in Somerset County. This group represents those classified as "indigent".

3. Persons Employed by Federal Works Projects

In Table 9, page 7, the total employed and awaiting employment by the Works Projects Administration of Maryland for the week ending June 19, 1940, has been shown. The largest number employed by this U. S. Government works project was 1,949 in Allegany and the lowest was 14 in Baltimore County. There were no Federal projects of this type in Calvert and Kent counties. In those counties in which the organization existed, the total employed per 1,000 population in the county of residence varied between 35.6 per 1,000 in Garrett and 0.2 in Baltimore County.

Those employed by the WPA would have been receiving assistance from the county welfare departments if this type of employment had not been provided by Federal, State and local governments. The average wage was about $45 per month.

During the year 1940 a total of 2,427 youths berween the ages of 17 and 23 years were employed in the Civilian Conservation Corps, another works agency of the Federal Government. The distribution by counties was not available. As a rule, these youths were members of households

[1] "Population of Maryland 1790-1930", a publication of the Maryland State Department of Health and the Maryland State Planning Commission.

TABLE 1

THE TOTAL POPULATION OF THE COUNTIES OF MARYLAND ACCORDING TO THE U. S. CENSUS TAKEN AS OF APRIL 1, 1940, TOGETHER WITH THE TOTAL WHITE, COLORED AND PERCENTAGE OF EACH.

	County	Total	White	Colored	PERCENT	
					White	Colored
	State of Maryland	1,821,244	1,518,481	302,763	83.4	16.6
	Baltimore City	859,100	692,705	166,395	80.6	19.4
	Total Counties	962,144	825,776	136,368	85.8	14.2
GROUP 1	Baltimore	155,825	145,295	10,530	93.2	6.8
	Prince George's	89,490	73,217	16,273	81.8	18.2
	Allegany	86,973	85,651	1,322	98.5	1.5
	Montgomery	83,912	74,986	8,926	89.4	10.6
	Washington	68,838	67,048	1,790	97.4	2.6
	Anne Arundel	68,375	50,524	17,851	73.9	26.1
	Frederick	57,312	52,607	4,705	91.8	8.2
	Carroll	39,054	36,973	2,081	94.7	5.3
GROUP 2	Harford	35,060	31,076	3,984	88.6	11.4
	Wicomico	34,530	27,035	7,495	78.3	21.7
	Dorchester	28,006	19,917	8,089	71.1	28.9
	Cecil	26,407	24,051	2,356	91.1	8.9
	Garrett	21,981	21,976	5	99.9	.1
	Worcester	21,245	14,575	6,670	68.6	31.4
	Somerset	20,965	13,904	7,061	66.3	33.7
	Talbot	18,784	13,048	5,736	69.5	30.5
GROUP 3	Charles	17,612	10,384	7,228	59.0	41.0
	Caroline	17,549	14,102	3,447	80.4	19.6
	Howard	17,175	14,369	2,806	83.7	16.3
	St. Mary's	14,626	9,901	4,725	67.7	32.3
	Queen Anne's	14,476	10,129	4,347	70.0	30.0
	Kent	13,465	9,404	4,061	69.8	30.2
	Calvert	10,484	5,604	4,880	53.5	46.5

TABLE 2

PROPORTION OF WHITE AND COLORED POPULATION IN THE COUNTIES OF MARYLAND, U. S. CENSUS 1940

	County	Percent	
		White	Colored
GROUP 1	Garrett	99.9	.023
	Allegany	98.5	1.5
	Washington	97.4	2.6
	Carroll	94.7	5.3
	Frederick	91.8	8.2
	Baltimore	93.2	6.8
	Cecil	91.1	8.9
	Harford	88.6	11.4
GROUP 2	Montgomery	89.4	10.6
	Howard	83.7	16.3
	Caroline	80.4	19.6
	Wicomico	78.3	21.7
	Prince George's	81.8	18.2
	Anne Arundel	73.9	26.1
	Dorchester	71.1	28.9
	Queen Anne's	70.0	30.0
GROUP 3	Worcester	68.6	31.4
	Kent	69.8	30.2
	Talbot	69.5	30.5
	Somerset	66.3	33.7
	St. Mary's	67.7	32.3
	Charles	59.0	41.0
	Calvert	53.5	46.5

TABLE 3

POPULATION DENSITY IN THE COUNTIES OF MARYLAND—PERSONS PER SQUARE MILE IN RURAL AREAS, U. S. CENSUS 1940 AND MARYLAND GEOLOGICAL SURVEY

	County	Total Population (1940)	Land Area in Square Miles	Persons per Square Mile
GROUP 1	Baltimore	155,825	607.4	256.5
	Allegany	86,973	425.2	204.5
	Prince George's	89,490	486.2	184.1
	Montgomery	83,912	497.0	168.8
	Anne Arundel	68,375	419.9	162.8
	Washington	68,838	458.5	150.1
	Wicomico	34,530	378.4	91.3
	Carroll	39,054	452.8	86.3
GROUP 2	Frederick	57,312	664.7	86.2
	Harford	35,060	442.8	79.2
	Cecil	26,407	351.2	75.2
	Talbot	18,784	271.8	69.1
	Howard	17,175	252.9	67.9
	Somerset	20,965	334.9	62.6
	Caroline	17,549	322.1	54.5
	Calvert	10,484	216.7	48.4
GROUP 3	Dorchester	28,006	580.9	48.2
	Kent	13,465	283.4	47.5
	Worcester	21,245	482.5	44.0
	St. Mary's	14,626	365.0	40.1
	Queen Anne's	14,476	375.4	38.6
	Charles	17,612	457.8	38.5
	Garrett	21,981	664.3	33.1

TABLE 4

PROPORTION OF FAMILIES RESIDING ON FARMS IN THE COUNTIES OF MARYLAND, U. S. CENSUS, 1940

	County	Percent of Families	
		Residing on Farms	Not Residing on Farms
GROUP 1	Allegany	6	94
	Baltimore	15	85
	Washington	17	83
	Montgomery	20	80
	Anne Arundel	22	78
	Prince George's	22	78
	Dorchester	26	74
	Cecil	28	72
GROUP 2	Kent	29	71
	Somerset	29	71
	Wicomico	29	71
	Talbot	30	70
	Frederick	31	69
	Carroll	40	60
	Harford	42	58
	Howard	43	57
GROUP 3	Worcester	43	57
	Caroline	44	56
	Queen Anne's	45	55
	Garrett	49	51
	St. Mary's	49	51
	Calvert	58	42
	Charles	61	39

receiving assistance from county welfare departments, or of families in which another member was employed by the Works Projects Administration.

Birth and Death Rates

1. Birth Rates

The average birth rates per 1,000 population for the years 1936-40 are included in Table 10, page 7. The highest average birth rates occurred in Charles County in which the average was 27.3 per 1,000, in contrast to 15.4 per 1,000 in Baltimore County. The birth rates for the white and colored are also included.

2. Death Rates

In Table 11, page 7, the average mortality rates per 1,000 persons for the years 1936-40 are shown. The average death rate varied between 15.7 in Somerset and 9.1 in Baltimore County. The average rates for white and colored are also tabulated.

The average annual deaths under one year of age per 1,000 population for the years 1936-40 have been computed in Table 12, page 7. The annual infant mortality rate was 106.1 in Worcester and 43.8 in Montgomery County. The annual infant mortality rates for the white and colored are also included. In all counties the rate for the colored was considerably higher than for the white.

Medical Care Facilities

The tables from which the following observations have been made will be found on pages 13, 21, 23 and 28.

1. Physicians in Active Practice

The physicians in active practice in the counties as of July 1, 1941, and the physician: population ratio have been shown in Table 16, page 13. The largest number of physicians was found in Baltimore County with 80, while there were only 5 in Calvert County. The physician: population ratio was highest, 1:962, in Kent and lowest, 1:2,442, in Anne Arundel County.

2. Registered Nurses

In Table 20, page 21, the active registered nurses in the counties have been tabulated by race, sex and the nurse: population ratio. The largest number of nurses were registered in Montgomery where there were 195 while there were only 4 in Garrett County. The nurse: population ratio ranged from 1:376 in Talbot to 1:5,495 in Garrett County.

3. Dentists

The distribution of dentists in active practice in 1940, and the dentist: population ratio is shown in Table 23, page 23. A total of 38 dentists were in practice in Baltimore County while there were no full-time dentists in Calvert. Of the remaining counties, the dentist: population ratio varied from 1:2,025 in Washington to 1:8,588 in Howard County.

4. Hospitals

In Table 25, page 28, the distribution of general hospitals* in 1940 together with the bed capacity and the hospital-bed: population ratios have been recorded. A total of 304 hospital beds were available in Allegany County while Calvert County had but 23 beds. The hospital-bed: population ratio extended between 1:172 in Talbot County and 1:2,098 in Montgomery. It should be noted that in 8 counties there were no general hospitals.

Summary Table

In all of the tables to which reference has been made, the principal subject has been arranged by rank.

In comparing figures for one county with those of another, it is obvious that in many instances the differences are not significant. In each of the tables, therefore, the first 8 counties have been considered an entity, designated as Group 1, the next 8 counties Group 2, and the remaining 7 counties Group 3. These figures are tabulated in Table 13, page 8, in which are compared 5 characteristics of the population, 3 on the economic status, 3 on the birth and death rates and 4 on the distribution of medical care facilities.

In the first column of Table 13, the population of each county has been classified in Groups 1, 2 and 3. In the columns which follow, it will be noted that the first 8 counties, with notable exceptions, are included, as a rule, in Group 1; the next 8 counties fall for the most part within Group 2; and the remainder, in general, are included in Group 3. The most striking exceptions are the households receiving assistance per 1,000 population, (Table 8) the average birth, general mortality and infant mortality rates, (Tables 10, 11 and 12) and the physician and dentist population ratios (Tables 16 and 23).

In general, it may be said that the counties with the greatest total populations have the highest proportion of white persons; the greatest population density; the highest proportion of urban residence; the greatest proportionate increase in population from 1790-1940; the highest income tax receipts per 1,000 population; and the highest registered nurse: population ratio. On the other hand, the counties in Group 1 have the lowest proportionate number of individuals receiving assistance and employed by the WPA, as well as the lowest birth, general and infant morrality rates. Conversely, in counties which have relatively low total populations, the characteristics are, in general, reversed.

*Unless otherwise specified, the term "hospital" as used throughout this report, connotes *general* hospital.

TABLE 5

THE TOTAL POPULATION OF THE COUNTIES OF MARYLAND ACCORDING TO THE U. S. CENSUS OF 1790 AND 1940, BY COLOR

	County	Year 1790			Year 1940		
		Total	White	Colored	Total	White	Colored
	State of Maryland	319,728	208,649	111,079	1,821,244	1,518,481	302,763
	Baltimore City	13,503	11,925	1,578	859,100	692,705	166,395
	Total Counties	306,225	196,724	109,501	962,144	825,776	136,368
GROUP 1	Allegany	4,809	4,539	270	86,973	85,651	1,322
	Anne Arundel	22,598	11,664	10,934	68,375	50,524	17,841
	Baltimore	25,434	18,953	6,481	155,825	145,295	10,530
	Calvert	8,652	4,211	4,441	10,484	5,604	4,880
	Caroline	9,506	7,028	2,478	17,549	14,102	3,447
	Carroll				39,054	36,973	2,081
	Cecil	13,625	10,055	3,570	26,407	24,051	2,356
	Charles	20,613	10,124	10,489	17,612	10,384	7,228
GROUP 2	Dorchester	15,875	10,010	5,865	28,006	19,917	8,089
	Frederick	30,791	26,937	3,854	57,312	52,607	4,705
	Garrett				21,981	21,976	5
	Harford	14,976	10,784	4,192	35,060	31,076	3,984
	Howard				17,175	14,369	2,806
	Kent	12,836	6,748	6,088	13,465	9,404	4,061
	Montgomery	18,003	11,679	6,324	83,912	74,986	8,906
	Prince George's	21,344	10,004	11,340	89,490	73,216	16,273
GROUP 3	Queen Anne's	15,463	8,171	7,292	14,476	10,129	4,347
	St. Mary's	15,544	8,216	7,328	14,626	9,901	4,725
	Somerset	15,610	8,272	7,338	20,965	13,904	7,061
	Talbot	13,084	7,231	5,853	18,784	13,048	5,736
	Washington	15,822	14,472	1,350	68,838	67,048	1,790
	Wicomico				34,530	27,035	7,495
	Worcester	11,640	7,626	4,014	21,245	10,767	10,478

TABLE 6

PERCENT INCREASE OR DECREASE IN THE POPULATION OF THE COUNTIES OF MARYLAND SINCE THEIR DATES OF ESTABLISHMENT

	County	Date of Establishment	Population on Date Established	Population in 1940	Percent Increase or Decrease Since Date of Establishment
GROUP 1	Allegany	1790	4,809	86,973	1708.5
	Baltimore	1790	25,434	155,825	512.7
	Montgomery	1790	18,003	83,912	366.1
	Washington	1790	15,822	68,838	335.1
	Prince George's	1790	21,344	89,490	319.3
	Anne Arundel	1790	22,598	68,375	202.6
	Harford	1790	14,976	35,060	134.1
	Carroll	1840	17,241	39,054	126.5
GROUP 2	Wicomico	1870	15,802	34,530	118.5
	Cecil	1790	13,625	26,407	93.8
	Garrett	1880	12,175	21,981	80.5
	Frederick	1790	30,791	57,312	86.2
	Caroline	1790	9,506	17,549	84.6
	Worcester	1790	11,640	21,245	82.5
	Dorchester	1790	15,875	28,006	76.4
	Talbot	1790	13,084	18,784	43.6
GROUP 3	Somerset	1790	15,610	20,965	34.3
	Howard	1860	13,338	17,175	28.8
	Calvert	1790	8,652	10,484	21.2
	Kent	1790	12,836	13,465	4.9
	St. Mary's	1790	15,544	14,626	−5.9
	Queen Anne's	1790	15,463	14,476	−6.4
	Charles	1790	20,613	17,612	−14.6

TABLE 7

INCOME TAX RETURNS PER 1,000 POPULATION, FROM THE COUNTIES OF MARYLAND, U. S. DEPARTMENT OF COMMERCE, 1938

	County	Returns per 1,000 Population
GROUP 1	Montgomery	129
	Prince George's	55
	Baltimore	38
	Allegany	33
	Anne Arundel	32
	Harford	26
	Howard	25
	Washington	25
GROUP 2	Talbot	22
	Cecil	21
	Frederick	18
	Wicomico	18
	Carroll	15
	Dorchester	15
	Charles	14
	Kent	13
GROUP 3	Queen Anne's	13
	Worcester	12
	Caroline	11
	Calvert	8
	Garrett	7
	St. Mary's	6
	Somerset	6

TABLE 8

HOUSEHOLDS RECEIVING ASSISTANCE FROM COUNTY WELFARE DEPARTMENTS IN MARYLAND IN 1940, AND THE NUMBER PER 1,000 POPULATION

	County	Total Population (1940)	Total Households Receiving Assistance (1940)	Households Receiving Assistance per 1,000 Population
	State of Maryland	1,821,244	29,616	16.3
	Baltimore City	859,100	15,313	17.8
	Total Counties	962,144	14,303	14.9
GROUP 1	Somerset	20,965	637	30.4
	Wicomico	34,530	1,000	29.0
	Queen Anne's	14,476	400	27.6
	Garrett	21,981	583	26.5
	Caroline	17,549	464	26.4
	St. Mary's	14,626	384	26.3
	Dorchester	28,006	717	25.6
	Worcester	21,245	486	22.9
GROUP 2	Talbot	18,784	412	21.9
	Calvert	10,484	229	21.8
	Cecil	26,407	554	21.0
	Kent	13,465	281	20.9
	Washington	68,838	1,378	20.0
	Charles	17,612	335	19.0
	Howard	17,175	307	17.9
	Harford	35,060	523	14.9
GROUP 3	Allegany	86,973	1,288	14.8
	Frederick	57,312	745	13.0
	Carroll	39,054	468	12.0
	Anne Arundel	68,375	605	8.8
	Montgomery	83,912	709	8.4
	Prince George's	89,490	749	8.4
	Baltimore	155,825	1,049	6.7

TABLE 9

TOTAL PERSONS EMPLOYED AND AWAITING EMPLOYMENT BY WORKS PROJECTS ADMINISTRATION OF MARYLAND FOR WEEK ENDING JUNE 19, 1940 AND THE NUMBER PER 1,000 IN THE COUNTY OF RESIDENCE

	County	Employed on WPA	Awaiting Employment on WPA	Total	Number per 1,000 Population in County of Residence
GROUP 1	Garrett	676	107	783	35.6
	Allegany	1,949	531	2,480	28.5
	Washington	1,437	266	1,703	24.7
	Frederick	1,050	99	1,140	20.0
	Wicomico	254	113	367	10.6
	Somerset	147	66	213	10.2
	St. Mary's	113	15	128	8.8
	Queen Anne's	92	30	122	8.4
GROUP 2	Worcester	128	49	177	8.3
	Harford	274	16	290	8.3
	Caroline	56	90	146	8.3
	Dorchester	70	150	220	7.9
	Howard	117	17	134	7.8
	Prince George's	468	27	496	5.4
	Anne Arundel	375	15	390	5.7
	Cecil	121	6	127	4.8
GROUP 3	Charles	71	14	85	4.8
	Carroll	137	5	142	3.6
	Montgomery	122	8	130	1.5
	Talbot	19	9	28	1.5
	Baltimore	14	14	28	0.2
	Calvert	None			
	Kent	None			
	Total	6,558	468	7,026	7.3

TABLE 10

ANNUAL BIRTHS PER 1,000 POPULATION IN THE COUNTIES OF MARYLAND. AVERAGE 1936-1940, CORRECTED FOR RESIDENCE

	County	Birth Rate		
		Total	White	Colored
GROUP 1	Charles	27.3	23.0	52.7
	Calvert	27.2	21.7	33.4
	St. Mary's	25.6	25.2	26.4
	Garrett	24.6	24.6	——
	Montgomery	22.4	22.5	22.0
	Howard	21.9	21.0	26.2
	Prince George's	21.5	20.9	24.2
	Allegany	19.8	19.8	20.9
GROUP 2	Anne Arundel	19.3	19.3	27.8
	Caroline	18.4	17.3	22.7
	Worcester	17.9	14.8	24.0
	Harford	17.8	17.3	22.5
	Queen Anne's	17.8	17.3	19.0
	Washington	17.7	17.7	16.4
	Frederick	17.6	17.3	21.3
	Dorchester	17.5	16.1	21.0
GROUP 3	Cecil	17.2	16.9	20.8
	Talbot	17.0	15.6	20.0
	Somerset	16.9	14.6	21.3
	Carroll	16.9	16.5	22.6
	Kent	16.2	14.8	19.4
	Wicomico	15.9	14.6	20.4
	Baltimore	15.4	15.4	16.2

TABLE 11

MORTALITY PER 1,000 PERSONS IN THE COUNTIES OF MARYLAND. AVERAGE 1936-1940, CORRECTED FOR RESIDENCE

	County	Average Annual Death Rate		
		Total	White	Colored
GROUP 1	Somerset	15.7	13.9	19.2
	Worcester	15.6	13.9	19.3
	Dorchester	14.7	12.5	19.8
	Kent	14.7	13.3	17.7
	Talbot	14.3	13.2	16.2
	Caroline	14.3	13.2	18.2
	Calvert	13.8	12.4	15.4
	Queen Anne's	13.4	12.2	16.4
GROUP 2	Wicomico	13.1	12.3	16.2
	Cecil	13.0	12.3	19.8
	Harford	12.5	11.6	20.1
	Carroll	12.4	12.1	17.9
	Frederick	12.4	12.0	15.9
	Howard	12.0	11.3	15.6
	St. Mary's	11.9	10.0	15.2
	Charles	11.6	9.9	13.7
GROUP 3	Montgomery	11.5	10.7	16.7
	Washington	11.0	10.6	26.5
	Garrett	10.9	10.9	——
	Anne Arundel	10.6	9.1	15.5
	Allegany	10.2	10.1	19.6
	Prince George's	10.2	9.4	13.5
	Baltimore	9.1	9.0	10.7

TABLE 12

DEATHS UNDER ONE YEAR OF AGE PER 1,000 LIVE BIRTHS IN THE COUNTIES OF MARYLAND .AVERAGE 1936-1940, CORRECTED FOR RESIDENCE.

	Cuoty	Annual Infant Mortality Rate		
		Total	White	Colored
GROUP 1	Worcester	106.1	70.0	154.3
	Calvert	97.2	69.7	116.5
	Dorchester	93.5	66.2	147.7
	Somerset	87.1	58.3	124.6
	Charles	80.2	53.4	103.1
	St. Mary's	78.8	63.0	106.7
	Kent	77.0	52.0	121.6
	Anne Arundel	70.5	49.9	84.9
GROUP 2	Queen Anne's	67.8	43.1	121.3
	Garrett	67.7	67.7	——
	Wicomico	67.6	59.4	72.2
	Talbot	65.8	48.1	98.0
	Cecil	59.1	55.0	91.3
	Caroline	58.6	51.2	81.3
	Frederick	57.9	53.1	100.2
	Allegany	57.4	57.1	74.8
GROUP 3	Prince George's	56.2	40.9	108.4
	Harford	55.7	50.8	84.9
	Washington	51.6	50.1	132.9
	Carroll	51.4	45.5	130.1
	Baltimore	45.0	41.7	79.7
	Howard	44.7	32.5	87.9
	Montgomery	43.8	34.8	105.5

TABLE 13

SUMMARY TABLE: CERTAIN CHARACTERISTICS OF THE POPULATION OF THE COUNTIES OF MARYLAND, THEIR ECONOMIC STATUS, BIRTH AND DEATH RATES AND DISTRIBUTION OF MEDICAL CARE FACILITIES ARE SHOWN. IN THE FIRST COLUMN THE POPULATION IS ARRANGED BY RANK. THE FIRST 8 COUNTIES HAVE BEEN DESIGNATED AS GROUP 1, THE NEXT 8 AS GROUP 2, AND THE LAST 7 AS GROUP 3. IN THE REMAINING COLUMNS EACH COUNTY HAS BEEN CLASSIFIED IN ACCORDANCE WITH THE NUMBER OF THE GROUP WITHIN WHICH IT FALLS IN THE ORIGINAL TABLE.

County	Population					Economic Status			Birth and Death Rates			Medical Care Facilities			
	Table (1) Population (1940)	Table (2) Percent White (1940)	Table (3) Population Density (1940)	Table (4) Percent Urban Residents (1940)	Table (6) Percent Increase or Decrease in Population (1790-1940)	Table (7) Income Tax Receipts Per 1,000 Population (1936)	Table (8) Households Receiving Assistance Per 1,000 Population (1940)	Table (9) Number Employed by the WPA Per 1,000 Population (1940)	Table (10) Average Birth Rate (1936-40)	Table (11) Average General Mortality Rate (1936-40)	Table (12) Average Infant Mortality Rate (1936-40)	Table (16) Physician Population Ratio	Table (20) Registered Nurse: Population Ratio	Table (23) Dentist: Population Ratio	Table (25) Hospital Bed: Population Ratio
1. Baltimore	1	1	1	1	1	1	3	3	3	3	3	3	1	2	**
2. Prince George's	1	2	1	1	1	1	3	2	1	3	3	3	1	3	**
3. Allegany	1	1	1	1	1	1	3	1	2	3	2	1	1	1	1
4. Montgomery	1	2	1	1	1	1	3	3	1	3	3	2	1	1	2
5. Washington	1	1	1	1	1	1	2	1	2	3	3	1	1	1	1
6. Anne Arundel	1	2	1	1	1	1	3	2	2	3	1	3	1	3	2
7. Frederick	1	1	2	2	2	2	3	1	2	2	2	1	2	1	1
8. Carroll	1	1	1	2	1	2	3	3	3	2	3	1	3	1	**
9. Harford	2	1	2	2	1	1	2	2	2	2	3	2	2	1	2
10. Wicomico	2	2	1	2	2	2	1	1	3	2	2	2	1	2	1
11. Dorchester	2	2	3	1	2	2	1	2	2	1	1	1	2	3	1
12. Cecil	2	1	2	1	2	2	2	2	3	2	2	3	2	1	2
13. Garrett	2	1	3	3	2	3	1	1	1	3	2	2	3	3	**
14. Worcester	2	3	3	3	2	3	1	2	2	1	1	2	3	1	**
15. Somerset	2	3	2	2	3	3	1	1	3	1	1	1	3	2	2
16. Talbot	2	3	2	2	2	2	2	3	3	1	2	1	1	2	1
17. Charles	3	3	3	3	3	2	2	3	1	2	1	2	3	3	2
18. Caroline	3	2	2	3	2	3	1	2	2	1	2	2	3	2	**
19. Howard	3	2	2	2	3	1	2	2	1	2	3	3	2	3	**
20. St. Mary's	3	3	3	3	3	3	1	1	1	2	1	3	3	2	1
21. Queen Anne's	3	2	3	3	3	3	1	1	1	1	2	2	2	2	**
22. Kent	3	3	3	2	3	2	2	*	3	1	1	1	2	2	2
23. Calvert	3	3	2	3	3	3	2	*	1	1	1	3	2	3	1

*No WPA project in this county.

**In 1940 there was no general hospital in this county.

Chapter III

PHYSICIANS' SERVICES

Changes in the Distribution of Physicians

In determining the changes in the distribution of physicians three years were selected—1909, 1923 and 1938—separated by intervals of fourteen and fifteen years, respectively.

In 1909 a total of 746 physicians were in active practice in Maryland outside the City of Baltimore. In 1923 the total was 850, and in 1938 it had reached 902. The population of the counties increased from an estimated total[1] of 732,229 in 1909, to 753,675 in 1923 and 938,433 in 1938. In 1909 the number of persons per physician was 888; in 1923, 793; and in 1938, 1,026. In Table 14, page 9, these data are shown together with the percentages of increase of physicians, population and persons per physician in 1938 over 1909.

TABLE 14

TOTAL PHYSICIANS IN THE COUNTIES OF MARYLAND IN 1909, 1923, AND 1938, THE ESTIMATED POPULATION, THE NUMBER OF PERSONS PER PHYSICIAN, AND THE PERCENTAGES OF INCREASE IN 1938 OVER 1909

Counties of Maryland	Year			Percent Increase in 1938 over 1909
	1909	1923	1938	
Total physicians	746	850	902	20.9
Estimated population	732,229	753,675	938,433	28.2
Persons per physician	888	793	1,026	15.5

The distribution of physicians in the years 1906 and 1940 is shown graphically in Charts I and II on pages 10 and 11. In 1906 it will be observed that the practitioners were quite uniformly distributed, whereas in 1940 a greater number of physicians was concentrated in the larger towns and cities.

The extent to which physicians have become concentrated is indicated by the observation that in 1906 there were only *eight* towns and cities in the State, outside of Baltimore City, which contained ten or more physicians, and the total number of physicians in these eight towns was 159. In 1940, however, there were *fourteen* towns and cities in which ten or more physicians were located, and the total equalled 325. It is clear, therefore, that the number of physicians located in towns had more than doubled in a period of 34 years.

This movement of physicians into the larger centers was no doubt due in part to a concurrent growth in the towns and cities. It probably was also the result of the attraction of physicians to general hospitals which were constructed in the centers of population during that period.

Advantages in Trend

Although the tendency of physicians to concentrate is very apparent, it does not seem to have reached proportions which, in view of the improvements in transportation, need be regarded with undue alarm. On the contrary, there are some obvious benefits in this change of distribution; (a) physicians living near a hospital will meet more frequently for consultation and discussion of professional problems, and (b) there are increased opportunities for the development of specialization.

Disadvantages of Concentration

Many have expressed the opinion that, because of the development of rapid transportation, an area of considerable size surrounding a town could be adequately covered by physicians resident in that municipality.

In the experience of the Committee, however, there is another side to the picture, in that the expense of physicians' visits is greatly increased for those living at a distance. The result is that calling a doctor is not infrequently postponed until harmful delay has made it evident that the condition is a serious one. During the field survey this opinion was emphasized by several physicians but more particularly by patients living more than a few miles from a physician. The latter complained that the cost of a single visit was high, and that if more than one or two calls were necessary, the expense was beyond their means. These patients declared that they were most anxious to have a physician live close at hand where, in case of need, he could be quickly summoned. It was also pointed out that a physician residing nearby could safely treat many types of illness in the home whereas, if he lived more than a few miles distant, it would be necessary to remove the patient to a hospital.

Decline in Number of Physicians in Some Areas

In general, those counties whose towns had great increases in population between 1906 and 1940 have shown an even greater increase in the number of physicians. For example, in Allegany County the number of physicians has risen from 28 in 1906 to 80 in 1938; in Wicomico County the number has increased from 20 to 29. In the counties adjacent to large cities, such as Baltimore, Prince George's and Montgomery counties, suburban developments also have led to increases in the number of physicians.

In counties with stationary or declining populations, however, the number of physicians has shown a striking

[1]Maryland State Department of Health, Bureau of Vital Statistics.

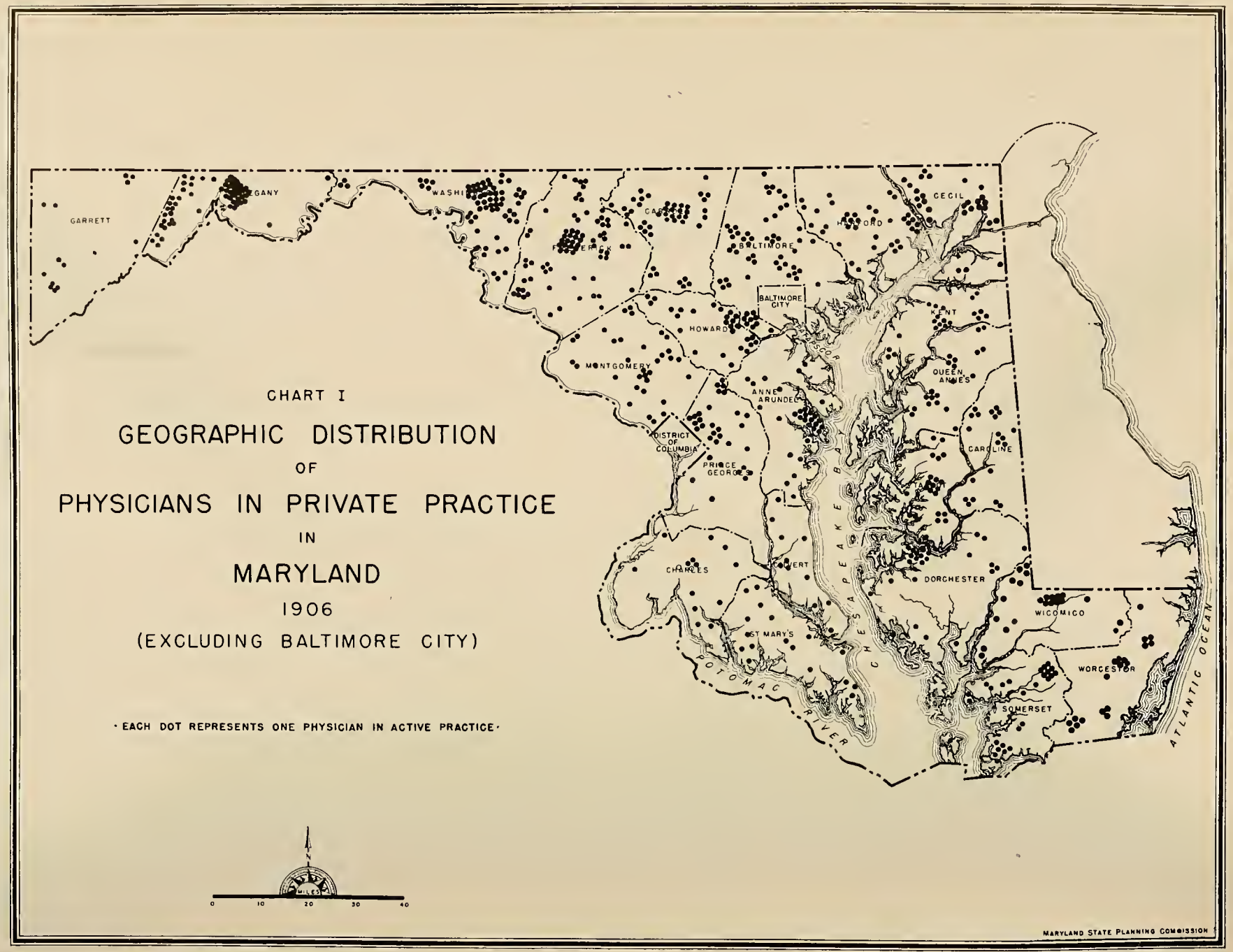


CHART I
GEOGRAPHIC DISTRIBUTION
OF
PHYSICIANS IN PRIVATE PRACTICE
IN
MARYLAND
1906
(EXCLUDING BALTIMORE CITY)
· EACH DOT REPRESENTS ONE PHYSICIAN IN ACTIVE PRACTICE ·
GARRETT
ALLEGANY
WASHINGTON
FREDERICK
CARROLL
BALTIMORE
HARFORD
CECIL
BALTIMORE CITY
HOWARD
KENT
MONTGOMERY
QUEEN ANNE'S
ANNE ARUNDEL
DISTRICT OF COLUMBIA
PRINCE GEORGES
CAROLINE
CHARLES
CALVERT
DORCHESTER
WICOMICO
ST MARY'S
WORCESTER
SOMERSET
POTOMAC RIVER
CHESAPEAKE BAY
ATLANTIC OCEAN
0 10 20 30 40
MILES
MARYLAND STATE PLANNING COMMISSION

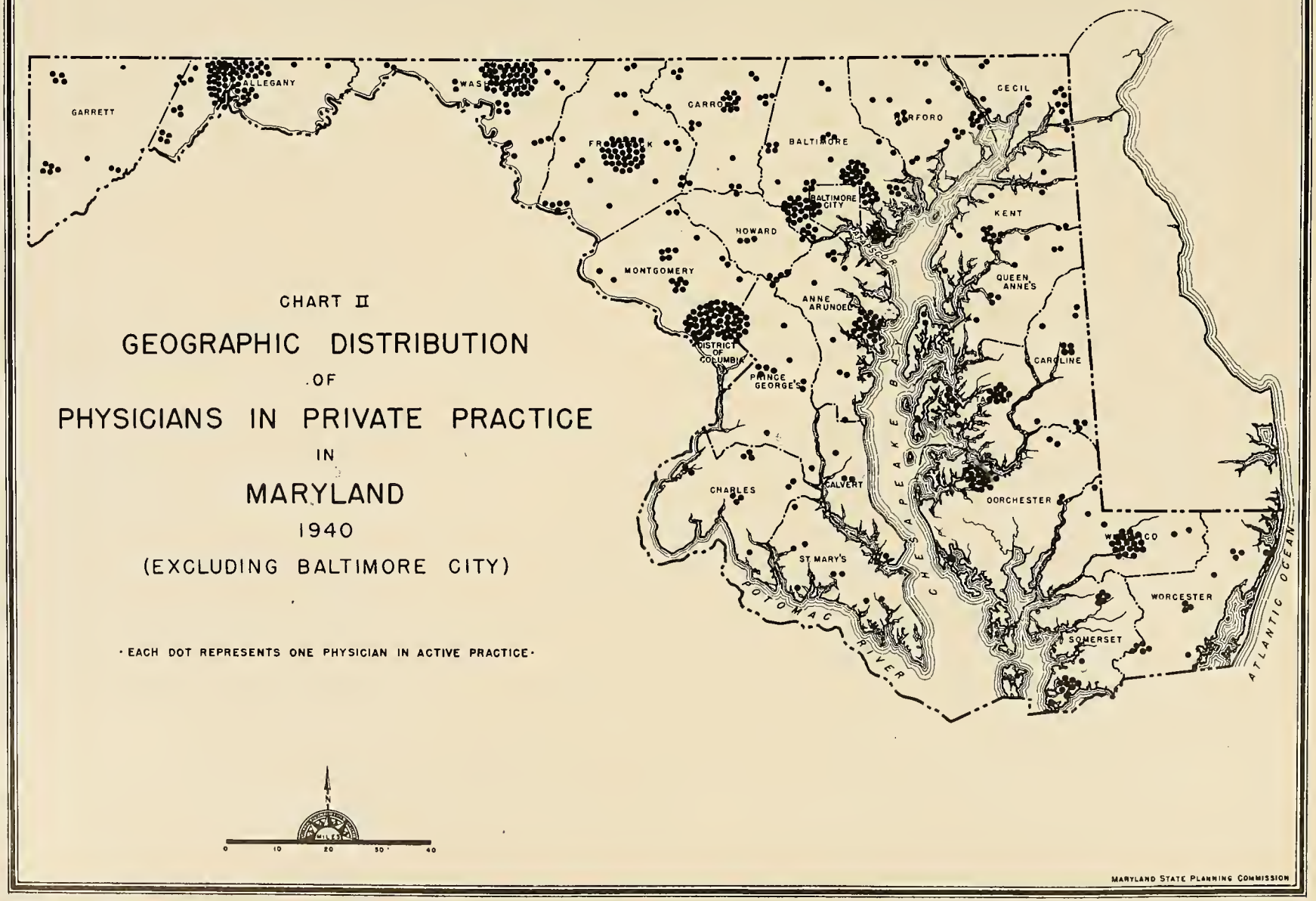


CHART II
GEOGRAPHIC DISTRIBUTION
OF
PHYSICIANS IN PRIVATE PRACTICE
IN
MARYLAND
1940
(EXCLUDING BALTIMORE CITY)
· EACH DOT REPRESENTS ONE PHYSICIAN IN ACTIVE PRACTICE ·
GARRETT
ALLEGANY
WASH
FREDERICK
CARROLL
BALTIMORE
HARFORD
CECIL
BALTIMORE CITY
KENT
HOWARD
MONTGOMERY
QUEEN ANNE'S
ANNE ARUNDEL
DISTRICT OF COLUMBIA
PRINCE GEORGE'S
CAROLINE
CHARLES
CALVERT
DORCHESTER
ST MARY'S
WORCESTER
SOMERSET
POTOMAC RIVER
CHESAPEAKE BAY
ATLANTIC OCEAN
0 10 20 30 40
MARYLAND STATE PLANNING COMMISSION

tendency to decrease. In Calvert County, for example, the number has been reduced from 9 to 6; in St. Mary's from 17 to 12, and in Caroline County from 22 to 16.

Changes in the Age Distribution

In view of better roads and improved transportation in the counties in which the population is stationary or declining, the decreased number of physicians might be expected to meet the needs of the county. However, a study of the age distribution of physicians in these counties indicates serious potentialities.

In 1906 there was only *one* county in Maryland in which the number of physicians over sixty years of age exceeded one third of the total number of physicians in the county. In 1940, in *nine* our of the twenty-three counties over one third of the physicians had passed the age of sixty. In one county, 13 of the 23 physicians were over sixty, in another 8 out of 12. Unless there is an influx of young physicians into these counties within the next decade, it is obvious that the day is not far distant when there will be a serious shortage of physicians.

Economic Status of Counties and Relative Number of Physicians

A partial analysis of collected data shows that, in general, there is a definite relationship between the economic status of each county and the number of practicing physicians under 40 years of age in the county. This partially completed study also has revealed that the lower the economic level of the county, the smaller the number of physicians who have become located there in the past decade.

Distribution of Physicians in 1941

On July 1, 1941, a total of 627 physicians were engaged in the private practice of medicine in the counties of Maryland. Of these, as indicated in Table 15, page 12, 580, or 93 percent were white males, 19, or 3 percent, white females, and 28, or 4 percent, colored males. Practitioners employed on a full-time basis in health departments, hospitals, sanatoria and other institutions were not included, and physicians residing in a county but practicing in Baltimore City and the District of Columbia also were omitted. The figures for the City of Baltimore and the State of Maryland also have been presented.

In Table 16, page 13, the distribution of physicians is shown, together with the physician: population ratio. It will be noted that the larter ratio varies between 1:962 in Kent County and 1:2,442 in Anne Arundel County.

A ratio of one physician per 1,500 population is generally regarded as a minimum for adequate medical care. Twelve counties possessed less than that ratio: Worcester, Harford, Caroline, Charles, Garrett, Cecil, St. Mary's, Baltimore, Prince George's, Calvert, Howard and Anne Arundel. Since Baltimore and Howard counties are adjacent to Baltimore City, and Montgomery and Prince George's are contiguous with the District of Columbia, residents of these areas have access to these large medical centers.

The Physician: Population Ratio

While one may compare the number of persons per physician in one county with that in another, the characteristics of the physicians in each may differ widely. For example, it was observed that one county possessed eight comparatively young doctors with quite extensive training and clinical experience, while in another of about the same total population there were eight older, less well trained and relatively inactive physicians. In the latter group one physician was president of a bank and devoted several hours each day to this activity, another owned two large farms and spent a considerable proportion of his working hours in their management. In the first county it was apparent that the problems of medical care were being met and solved to a notable degree, while in the second little progress was observed, and, incidentally, fears of the possible advent of "State medicine" were frequently expressed.

TABLE 15

TOTAL PHYSICIANS IN ACTIVE PRACTICE IN THE STATE OF MARYLAND, JULY 1, 1941, BY COLOR AND SEX. PRACTITIONERS EMPLOYED FULL-TIME IN HOSPITALS, SANATORIA AND HEALTH DEPARTMENTS ARE NOT INCLUDED

	Number of Physicians				
	Total	White		Colored	
		Male	Female	Male	Female
State of Maryland	1956	1801	57	96	2
Baltimore City	1329	1221	38	68	2
Total Counties	627	580	19	28	0
Allegany	69	64	3	2	
Anne Arundel	28	23	2	3	
Baltimore	80	74	2	4	
Calvert	5	5			
Caroline	11	10		1	
Carroll	31	30	1		
Cecil	15	13	1	1	
Charles	11	11			
Dorchester	21	18	1	2	
Frederick	50	47		3	
Garrett	13	13			
Harford	23	22		1	
Howard	8	8			
Kent	14	13		1	
Montgomery	58	50	7	1	
Prince George's	43	40		3	
Queen Anne's	10	10			
Saint Mary's	8	8			
Somerset	15	12	1	2	
Talbot	17	14	1	2	
Washington	59	59			
Wicomico	24	22		2	
Worcester	14	14			

TABLE 16

PHYSICIANS IN ACTIVE PRACTICE IN THE STATE OF MARYLAND, JULY 1, 1941, AND THE PHYSICIAN: POPULATION RATIO. PRACTITIONERS EMPLOYED FULL-TIME IN HOSPITALS, SANATORIA AND HEALTH DEPARTMENTS ARE NOT INCLUDED

	Total Practicing Physicians	Physician: Population Ratio
State of Maryland	1,956[1]	1: 931
Baltimore City	1,329[2]	1: 646
Total Counties	627	1:1,534
Kent	14	1: 962
Talbot	17	1:1,105
Frederick	50	1:1,146
Washington	59	1:1,167
Allegany	69	1:1,258
Carroll	31	1:1,260
Dorchester	21	1:1,334
Somerset	15	1:1,398
Wicomico	24	1:1,439
Montgomery	58	1:1,447
Queen Anne's	10	1:1,448
Worcester	14	1:1,518
Harford	23	1:1,524
Caroline	11	1:1,595
Charles	11	1:1,601
Garrett	13	1:1,691
Cecil	15	1:1,760
St. Mary's	8	1:1,828
Baltimore	80	1:1,948
Prince George's	43	1:2,081
Calvert	5	1:2,097
Howard	8	1:2,147
Anne Arundel	28	1:2,442

[1]Totals 2,464, or 1:739 when internes and residents are added.
[2]Totals 1,837, or 1:468 when internes and residents are added.

In addition to age, training and activity, other factors which discount the significance of the physician: population ratio as an index of the distribution of medical care are: variations in race, economic status, density of population, differences in climate, terrain, transportation, and the presence or absence of hospitals.

To obtain an accurate picture of the medical services available to the population of a given county, consideration must also be given to the services rendered by local physicians to non-residents, as well as to the proportion of county residents who usually secure medical services from physicians living outside its boundaries. In several counties of Maryland, these factors appear to have considerable importance.

Age Distribution in 1941

The age distribution of practicing physicians varied widely from county to county. In Table 17, page 13, the total in the age groups under 45, 45-64, and 65 and over are shown, as well as the percentage in each group. In many instances the numbers are small and one or two, more or less, in one group would produce a grear variation in the percentage. A comparison of the proportions in most instances, therefore, is not significant. It will be noted that Calvert, Caroline, Garrett, Prince George's and Wicomico counties have the highest percentage of physicians under 45 years, and St. Mary's, Worcester, Kent and Dorchester counties have the highesr proportion over 65 years of age.

During the survey it was observed thar many of the older physicians, stimulated by a patrioric desire to render the greatest possible service during "the emergency", appeared as alert and energetic as the average young man. However, it must be conceded that activity, in general, decreases with the passage of years and, therefore, the age distribution of physicians is of considerable significance in measuring the *quantity* of medical care in a particular locality.

TABLE 17

PHYSICIANS IN ACTIVE PRACTICE IN 1940 IN THE COUNTIES OF MARYLAND IN THE AGE GROUPS—UNDER 45, 45-64, 65 AND OVER—TOGETHER WITH THE PERCENTAGES IN EACH GROUP

	Total Physicians	Total in Age Groups			Percent in Age Groups		
		Under 45	45-64	65 & Over	Under 45	45-64	65 & Over
State of Maryland	1,956	851	826	279	43	42	15
Baltimore City	1,329	564	576	189	42	43	15
Total Counties	627	287	250	90	46	40	14
Allegany	69	29	35	5	43	42	15
Anne Arundel	28	15	12	1	52	38	10
Baltimore	80	46	29	5	57	36	7
Calvert	5	4	1	—	80	20	—
Caroline	11	7	3	1	64	27	9
Carroll	31	12	12	7	32	42	26
Cecil	15	4	10	1	25	56	19
Charles	11	6	2	3	54	19	27
Dorchester	21	11	6	4	35	35	30
Frederick	50	16	20	14	32	40	28
Garrett	13	8	3	2	60	20	20
Harford	23	11	8	4	46	37	17
Howard	8	3	4	1	50	40	10
Kent	14	3	6	5	21	44	35
Montgomery	58	29	24	5	50	41	9
Prince George's	43	23	12	8	60	22	18
Queen Anne's	10	3	5	2	30	50	20
Saint Mary's	8	2	2	4	25	25	50
Somerset	15	4	8	3	21	58	21
Talbot	17	5	8	4	33	45	22
Washington	59	28	25	6	45	39	16
Wicomico	24	13	10	1	59	37	4
Worcester	14	5	5	4	31	31	38

Relative Activity

Physicians in the counties of Maryland were classified on the basis of proportion of working hours said to be devoted to the practice of medicine. Of 627 practitioners, 92 or 14.7 percent were classified as parr-time physicians. Physical disability was said to be the cause in all except five. Of the 92 physicians, 2 were below 45 years, 42 be-

tween 45 and 64, while 48 were over 65 years of age. The total physicians in active practice, the total part-time physicians, and the percentage in part-time practice are tabulated below:

Age Groups	Physicians in Active Practice	Physicians in Part-time Practice	Percent in Part-time Practice
Under 45 years	287	2	.7
45-64	250	42	16.8
65 and over	90	48	53.3
Total	627	92	14.7

Specialization

In 1941, a total of 186, or 30 percent of the 627 practicing physicians, either limited their practice or asserted that a large proportion of their time was devoted to a specialty. In Table 18, page 14, the physicians in each of these groups are enumerated by counties.

Specialists were concentrated in the largest centers of population, notably in Allegany, Washington, Frederick and Wicomico counties. There were three counties that did not possess a specialist of any kind.

In Table 19, page 15, the total specialists and their field of specialty are listed. The most frequent forms of limited practice included surgery, eye, ear, nose and throat, obstetrics and gynecology, pediatrics and internal medicine. These data are based upon declarations of physicians.

PHYSICIANS AND THE PROBLEMS OF MEDICAL CARE

Physicians Interviewed

It was originally planned to interview all physicians in the counties and obtain from each a summary of the local problems in medical care and elicit their opinions as to the methods by which these problems might best be solved. When the field survey was terminated, all or nearly all practitioners in the following counties had been interviewed:

1. *Western Maryland*
   - (a) Garrett County
   - (b) Allegany County
   - (c) Washington County
2. *Southern Maryland*
   - (a) Calvert County
   - (b) St. Mary's County
   - (c) Charles County
3. *Eastern Shore of Maryland*
   - (a) Somerset County
   - (b) Worcester County
   - (c) Talbot County

A total of 88 or 15 percent of the 627 physicians were interviewed. In addition to those who were seen formally, more than 100 were interviewed quite informally in other counties of the State.

Characteristics of Physicians Interviewed

Of the 88 recorded interviews, 35 (40 percent) were below 40 years of age, 27 (31 percent) were between 40 and 59 years, and 26 (29 percent) were 60 years or over. Among all the practicing physicians of the State, the percentages in each of these three age groups were 31, 44 and 25, respectively. In regard to age, therefore, a fairly representative sample was selected.

TABLE 18

TOTAL PHYSICIANS AND SPECIALISTS IN THE STATE OF MARYLAND JULY 1, 1941

	Total Physicians	Number of Specialists	
		Total*	Practice Limited to Specialty**
State of Maryland	1,956	817	Unknown
Baltimore City	1,329	631	Unknown
Total Counties	627	186	71
Allegany	69	39	24
Anne Arundel	28	9	1
Baltimore	80	23	6
Calvert	5	1	
Caroline	11	2	
Carroll	31	1	
Cecil	15	7	
Charles	11		
Dorchester	21	6	1
Frederick	50	17	6
Garrett	13	1	1
Harford	23	5	
Howard	8		
Kent	14	2	1
Montgomery	58	21	5
Prince George's	43	5	
Queen Anne's	10		
Saint Mary's	8	1	
Somerset	15	2	1
Talbot	17	6	2
Washington	59	25	17
Wicomico	24	10	6
Worcester	14	3	

*Physicians in the group asserted that they were specialists and that they devoted most of their working hours to a limited practice.

**Practice strictly limited.

The majority of these physicians practiced in rural areas or small towns. Only 9 (10 percent) practiced in a purely urban environment. Approximately 18 percent of the physicians declared that their patients resided within a

radius of less than 5 miles, 60 percent stated that the distance was from 5 to 10 miles, while 22 percent declared that the radius was greater than 10 miles.

Of 65 physicians who presented estimates, almost 30 percent stated that their annual net income was over $5,000, while 15 percent declared that the figure was less than $3,000. The remainder, or 55 percent, said that their net incomes were between $3,000 and $5,000 per year.

Sixty-six out of 70 physicians were members of a county medical society, and most of them said that they were active in its work.

Although there was no hospital in two of the counties in which these physicians resided, two-thirds of the practitioners were members of the staff of a hospital in their own or in an adjoining county.

Topics Discussed and Opinions Expressed

With a high proportion of these physicians, the following specific topics were discussed:

1. Local facilities for medical care.
2. Availability of physicians' services to the total population.
3. Local provisions for the care of the medically indigent.
4. Proportion of physicians' time devoted to care of medically indigent.
5. Recommended changes in the present provisions for medical care of the indigent.
6. Experiences with programs for medical care of indigent in adjoining states.
7. Experiences with medical service systems in industrial groups.
8. The advisability of adopting a system of public payment for medical care for (a) those on relief and (b) those in low income groups.
9. Opinions on provisions of public payment systems relating to (a) choice of physician, (b) compensation and (c) administration.

TABLE 19

TOTAL SPECIALISTS[1] AND THEIR FIELDS OF SPECIALTY IN THE STATE OF MARYLAND, JULY 1, 1941

	Total Specialists	Internal Medicine	Surgery*	Obstetrics & Gynecology	Pediatrics	Urology	Eye, Ear, Nose and Throat**	Psychiatry***	Radiology	Dermatology	Industrial Medicine	Pathology	Anaesthesia
State of Maryland	817	145	169	123	85	43	111	35	29	19	30	13	15
Baltimore City	631	129	123	97	63	34	79	33	19	17	17	11	9
Total Counties	186	17	46	25	22	9	32	2	10	2	13	2	6
Allegany	39	4	10	4	3	3	9		3	1	2		
Anne Arundel	9	1	2	2	1		3						
Baltimore	23	1	4	3	4		3			1	6		1
Calvert	1		1										
Caroline	2				2								
Carroll	1											1	
Cecil	7		2	1	1				1		2		
Charles	—												
Dorchester	6		3	1			1				1		
Frederick	17	2	4		2	2	3	2	1				1
Garrett	1										1		
Harford	5		2	2	1								
Howard	—												
Kent	2		1	1									
Montgomery	21	6	3	5	1		2		2				2
Prince George's	5		2		2						1		
Queen Anne's	—												
Saint Mary's	1		1										
Somerset	2		1										1
Talbot	6		2	1	1	1			1				
Washington	25	3	4	4	3	2	6		1			1	1
Wicomico	10		4	1	1		3		1				
Worcester	3					1	2						

[1]Based upon declarations of physicians.
*Including Orthopedics and Neurosurgery.
**Including Otolaryngology and Ophthalmology.
***Including Neuropsychiatry.

1. *Local Facilities for Medical Care*

(a) *Consultants*

Of 69 physicians who discussed the subject, 58 said that they rarely had great difficulty in securing the services of a consultant, however that consultants' services were by no means routinely available. In most instances consultants were located in the larger medical centers and it sometimes was necessary for them to travel a considerable distance to confer with county physicians. Many practitioners stated that if the same consultants were called each time, and if fees were received from those able to pay, little difficulty was experienced in obtaining occasional consultants' services for the medically indigent.

Physicians in the more remote areas, however, stated that since the distance to the nearest medical center was great, it was too expensive for all but a very few of their patients to procure the services of a consultant. The other alternative was a long drive to the medical center and hospitalization of a patient who otherwise might have been treated in the home.

(b) *Hospitals*

(i) *General Hospitals*

A high percentage of physicians expressed the belief that the usefulness of small hospitals was limited on account of the absence of a resident staff, and because of the necessity of treating a wide variety of conditions for which adequate facilities were not available.

A number of doctors said that they hesitated to send their patients to the larger hospitals in Baltimore and in the District of Columbia because in doing so they incurred the displeasure of some of their local associates. This group expressed the hope that something might be done to make consultants' services more readily available in local hospitals.

In deciding whether a patient should be sent to a hospital, the distance to the institurion from the physician's office was somerimes a matter of serious moment. If the rype of illness made it necessary for the physician to visit the hospital each day, a distance of five or six miles might make the cost prohibitive to the patient.

Another reported difficulty was that hospital administrators, except in very obvious emergencies, seemed prone to discourage the admission of free and even part-pay patients. In more than one area physicians bitterly complained that they were frequently subjecred to cross-examination as to the urgency of the need for hospital care for an indigent patient. The Commirtee on Medical Care was urged to recommend that the hospitalization of the medically indigent be placed on a more equitable basis.

In several instances the necessity for restricting admissions was said to be a lack of accommodations and hospital personnel. In others this was not the case. In the opinion of some physicians, several hospitals appeared to be receiving funds from State, city and county governments in amounts sufficient to provide hospitalization for a larger proportion of indigent patients than were being admitted.

Nearly all of the physicians reported that it was practically impossible to hospitalize a normal indigent obstetrical case, and that an abnormal case sometimes had to be almost *in extremis* before the patient could be admitted.

In many institutions the number of beds provided for Negro parienrs was said to be inadequate. A few were reported to have excellent facilities for the care of Negroes.

(ii) *Chronic Disease Hospitals*

The lack of institutions for the treatment of patients suffering from chronic disease was unanimously deplored.

It was pointed out that the large majority of the chronically ill could not afford the services of a graduate nurse in the home, and that it was almost impossible to provide adequate care for such patients without; (a) immobilizing a general hospital bed for a long period, provided the patient could be admitted to a hospital; (b) overloading the physician so that he would be unable to treat all patients who were acutely ill; (c) exhausting the financial resources of the patient and his family.

(iii) *Home Nursing*

Outside the hospitals centers there were said to be relatively few graduate nurses because, in the opinion of physicians, a very small proportion of their patients could afford to pay the cost. "Practical nurses" were found to be more numerous. These were individuals who either had a limited amount of hospital training, or, believing that they possessed an aptitude for this type of work, considered rhemselves qualified by experience.

Since skilled nursing service can not, as a rule, be secured in the rural areas which comprise a large part of the State, the suggestion was advanced by a number of physicians that pracrical nurses should be made more generally available, and that those now active should be encouraged or even required to take a course of training in standard nursing procedures so that they might be better prepared to render more efficient service. It was fully realized by these physicians that most nursing authorities considered such developments unsound and unwarranted.

In the absence of adequate and inexpensive nursing service in the home, the alternative, in the opinion of physicians is the hospitalization of a patient who otherwise might not require institutional care. In that event, the hospital expenses frequently are greater than the financial resources of the patient and the public is compelled either to bear the entire cost or to underwrite the difference.

(iv) *Drugs and Medical Supplies*

In most rural areas, drugs and other medical necessities can not be purchased within a reasonable distance. A large majority of physicians, therefore, find it necessary to dispense drugs and other medical supplies. One of the unfortunate consequences, from the standpoint of the physician, is that for the medically indigent a practitioner not only must render professional services without compensation but also furnish the drugs.

(v) *Post Graduate Training for Physicians*

In order to keep abreast of medical progress, physicians stated that it usually was necessary to attend lectures and clinics in relatively distant points with loss of valuable time.

Many practitioners expressed the desire for the re-establishment of refresher courses formerly conducted throughout the State by the Medical and Chirurgical Faculty.

2. *Availability of Physicians' Services to the Total Population*

Physicians almost invariably agreed that there were unmet needs in their community, and in most cases they did not hesitate to indicate the magnitude of such needs. Nearly all of those interviewed expressed the belief that in their community there were persons who, because they lacked sufficient funds, were unable at times to obtain medical care, and that there were others who, having little cash or credit, sometimes delayed calling a physician even to the point of danger. In several counties, particularly in those in which the proportion of physicians over 50 years of age was high, a majority of the doctors declared that they would not be surprised if indigent patients complained that they could not get medical attention at times other than during the usual office hours.

On the other hand, a number of physicians asserted that they never had declined to treat a case regardless of financial status and there was abundant evidence that this was the case. One doctor said "I have never turned down a patient in my life", and added with a twinkle "but, believe me, I've done a hell of a lot of grumbling in my time".

In chronic illness the situation was quite different. In the absence of home nursing service and chronic disease hospitals there were "more than a few" who, physicians declared, did not receive adequate medical care.

3. *Local Provisions for the Care of the Medically Indigent*

Under the public welfare laws, no specific provision is made for medical care except as can be included in the budget of the individual. Relief clients must make their own arrangements for doctors. No authorization is necessary, but proof of medical expenses is required for budgetary purposes. This has resulted in different procedures in many of the counties, and among the physicians there was wide-spread and almost unanimous dissatisfaction with the effort to provide medical care for those who were receiving relief. Of 72 practitioners interviewed, only 3 expressed any degree of approval of these attempts.

The chief criticisms have been classified as follows:

(a) Because of the complicated system for authorizing even the limited payments for physicians' services available under the former relief program, most physicians still felt there was considerable red tape involved.

To avoid filling out complex forms some physicians preferred to continue to treat these patients as "charity cases", as they always had done, and forget about the possibility of receiving compensation; others declined to treat welfare cases.

Typical comments were: (i) "I do not bother putting their accounts on my books because I know that I will not be paid more than a quarter of the time," and (ii) "As for welfare patients—I never accept them since entirely too much red tape is involved."

Physicians objected to the necessity for prolonged debates with welfare workers as to the need for repeated visits to patients, particularly in cases in which medical judgment was involved.

Due to complex procedures it was reported that harmful delays sometimes occurred in providing patients with drugs which the physician did not possess.

(b) A few of the county welfare departments contracted with the physician to treat a recipient of relief but the doctor was compelled to collect from the patient.

In several counties in which arrangements had been made by the welfare department to compensate physicians, at least in part, for service to relief cases, the amount agreed upon was added to the monthly check of the welfare case. Physicians believed that patients often were urged by welfare workers to pay their bills. If, however, the physician did not happen to be in the vicinity on the day on which the next check was received, according to physicians, the account was paid in only about 25 percent of cases. A number of physicians said that they did not always blame the welfare cases because in many instances the amount of the check was small. However, in their opinion, if a specific portion of the check had been allocated for medical care or other legitimate expenditures, it seemed reasonable to expect, as a matter of principle, that the money would be expended for that purpose.

(c) If a patient dies before a welfare check is mailed the check becomes null and void and the physician can not collect rhe amount due.

(d) The opinions of five of the 69 critics were summarized in the words of one who said "The people on relief are being pauperized. They used to ask for medical assistance and say 'thank you' when it was given, and the service was rendered cheerfully. Now they come ro us demanding attention without expecting or offering to pay even a penny for it. The whole system, in my opinion, is wrong."

(e) The opinions of another group were epitomized in the words of one of their number: "Many of rhese unfortunate people are on relief because they were unable to manage their own financial affairs, and yet these same individuals are now expected to act wisely in expending funds received from governmental sources. Furthermore, I can not understand why the Federal, State and local governments require strict accounting for every nickel of all other types of appropriations, and in these expenditures of very large sums, there appears to be no thought of requiring the recipients to render an accounting."

4. *Proportion of Physicians' Time Devoted to Treatment of Medically Indigent*

On the basis of statements of 58 physicians, the proportion of patients given free medical services varied from 10 to 50 percent with an average of approximately 30 percent. It would appear, therefore, that physicians, on an average, contributed about one-third of their time and talents to the care of the medically indigent.

About 30 percent of physicians reported that during the preceding five-year period their ability to earn a livelihood had been definitely impaired by the magnitude of the free and part-pay patient load they were obliged to carry.

5. *Recommended Changes in Present Provisions for Medical Care of the Indigent*

The following modifications in the present system for providing medical care for the indigent were suggested by physicians:

(a) The reduction of "red tape" to a minimum.

(b) The establishment of a definite fee schedule.

(c) Legislation to make possible direct compensation of physicians by the welfare departments.

(d) Greater participarion of county medical societies.

6. *Experiences with Programs for Medical Care of Indigent in Adjoining States*

In contrast to the general dissatisfaction with provisions for the medical care of welfare cases in the counties of Maryland, many physicians in Western Maryland expressed quite enthusiastic approval of the provisions for medical care of the indigent in West Virginia and Pennsylvania. Most of these physicians had personal experience with these programs since some of their patients resided in one or the other of these States.

It was decided to investigate these plans in as much detail as time would permit. Four physicians in each of these States were interviewed. The impression was gained that these physicians were reasonably well satisfied with most of the provisions of the programs. However, a number of objections were raised which had not been mentioned by Maryland physicians. While there were certain fundamental differences in the plans in West Virginia and in Pennsylvania, features common to both appeared to be as follows:

(a) The *first* call to a welfare case was usually made without preliminary authorization, thus avoiding unnecessary delay in instituting treatment..

(b) Physicians' statements were presented to a committee of the county medical society each month. After being reviewed and, if necessary, revised, the bills were forwarded to the county welfare department for payment.

(c) If full payment were not received, physicians were sure that *some* compensation would be forthcoming.

(d) The "red tape" was minimal.

7. *Experiences with Medical Service Systems in Industrial Groups*

In two counties, Allegany and Garrett, physicians have had long experience with medical services in industrial groups. In some of the mines and other industries of the region a check-off system, not unlike the British panel system, was in operation.

In each family all workers over 21 years of age entered into a contract with a physician, through the company by which they were employed. Under the terms of this contract $2 a month was paid for medical care in the home and in the physician's office. All members of the family were entitled to receive treatment without additional charge. Professional services for obstetrical cases, accidents and venereal disease were not included.

It was stated that collections from employees were made each pay day and, as a rule, a collection charge (reported to have been 5%), was deducted before the company paid the balance to the physician named by the employee. It was said that the physician had the right to accept or reject the application of any worker.

On the whole, this system seemed to be regarded with favor but the following misgivings were expressed:

(a) Some patients called physicians to their homes for minor illnesses while others sometimes came to the office for trivial reasons, presumably because they wished to "get something in return".

(b) If employment was irregular, the physicians' income also was variable.

(c) In order to be assured of adequate remuneration for treatment of the group, physicians estimated that they must have *at least* one hundred employees under contract.

(d) It was stated that occasionally one physician or a group of physicians seemed, in one way or another, to secure the enlistment of a high percentage of the employees of a particular company, leaving few for other doctors in the area.

(e) Patients who had a relatively high income obtained medical care at a cost considerably less than they otherwise would have been expected to pay.

8. *The Advisability of Adopting a System of Public Payment for Medical Care for (a) Those on Relief and (b) Those in Low Income Groups*

A total of 77 physicians were asked this question: "Do you favor the adoption of a well-controlled plan for public payment for medical care for (a) those on relief and (b) those in the low income group?" By the term "well-controlled" it was implied that under the plan the interests of both physicians and patients would be properly safeguarded. The responses were classified as follows:

(i) Fifty-eight (76 percent) favored a public payment plan for medical care for relief cases. Of this number, 22 physicians also favored a plan for those with low incomes.

(ii) Eleven (14 percent) were satisfied with existing conditions.

(iii) Eight (10 percent) were non-committal.

From the foregoing, it is obvious that the large majority of physicians favored the development of a well-controlled program for the public payment for medical care for "those on relief". Of this group, 22 physicians expressed the opinion that those in the low income group also should be included.

Of the 11 physicians in group (ii), nine expressed the fear that the introduction of such a plan would be "just one more step in the direction of socialized medicine" while two asserted that "all is well".

The 8 physicians in group (iii) included: (a) Older physicians who preferred to leave settlement of the question in the hands of younger men; (b) Those who professed lack of interest because all their patients were in the higher income brackets; (c) Those who declined to express an opinion.

9. *Opinions on Provisions of Public Payment Systems Relating to (a) Choice of Physician, (b) Compensation, and (c) Administration*

(a) *Choice of Physician*

All physicians were in agreement on one point, namely, that any plan that may be developed should provide for freedom of choice of physicians by all its beneficiaries.

(b) *Compensation*

Physicians desired assurance of receiving payment for services rendered, but opinion was almost equally divided as to whether full or reduced fees should be charged.

(c) *Administration*

In the opinion of most physicians such a plan could best be administered by the county health department in collaboration with the county medical society. In two counties the formation of a new organization for administrative purposes was advocated. These were areas in which the administration of the county health departments did not appear to meet the general approval of the medical profession. A very small number of physicians thought that the work could be done by county commissioners or by the welfare department.

While it was realized that there were many problems in medical care common to all counties, there was scarcely a county, in the opinion of physicians, that did not possess problems peculiar to that locality. It was agreed that a State agency should formulate and administer general policies. In the interests of achieving maximum efficiency, however, it was considered advisable to establish in each county an administrative unit with power to modify a State policy, within appropriate limits, in order to solve a specific local problem.

Summary

Since 1906 the proportion of physicians in active practice in the cities and towns of Maryland has increased to a significant degree. Concurrently, a marked decrease in the number of physicians has occurred in counties with stationary or declining populations.

In the counties in the lower economic level, the proportion of physicians over 60 years of age was high. In the absence of a flow of young practitioners into these areas within the next ten years, a serious shortage is inevitable.

In 1941, a total of 627 physicians were in active practice in the counties. Of these 580, or 93 percent, were white males; 9, or 3 percent were white females; and 28, or 4 percent, were colored males.

The number of persons per physician varied between 1:962 in Kent and 1:2,442 in Anne Arundel County.

Calvert, Caroline, Garrett, Prince George's and Wicomico had the highest percentage of physicians under 45 years, and St. Mary's, Worcester, Kent and Dorchester had the greatest proportion over 65 years of age.

Of 627 practitioners, 92, or 14.7 percent were classified as part-time physicians, chiefly on account of physical disability.

In 1941, a total of 186, or 30 percent of 627 physicians, declared that they devoted all or nearly all of their working hours to the practice of a specialty.

A total of 88, or 15 percent of the 627 physicians in 9 counties, were interviewed at length. These comprised a large majority of practitioners in these counties.

Physicians interviewed were representative in age, most of them were engaged in rural practice within a radius of 5 to 10 miles from their office, had a net income of from $3,000 to $5,000 per year, belonged to the county medical society and to the visiting staff of a hospital.

Physicians in *remote* areas reported inability to secure consultants, except in unusual circumstances.

The need for a resident medical staff and consultants in local hospitals was stressed.

Difficulties in obtaining hospitalization, particularly for medically indigent, and especially for normal obstetrical cases were reported.

The absence of chronic disease hospitals was almost unanimously deplored.

It was declared that only a small proportion of the population was able to pay for graduate nursing service in the home. Difficulties were also reported in obtaining graduate nurses for duty in small hospitals. The training of "practical" nurses was suggested.

In most rural areas physicians dispensed drugs and other medical necessities to those who could pay as well as to those who could not.

Physicians almost invariably agreed that in their counties there were persons who, because they lacked sufficient funds, were unable at times to obtain medical care, and that there were others who, having little cash or credit, sometimes delayed calling a physician even to the danger point. The proportion of such persons was thought to be considerably higher among the chronically ill than in acute cases.

Among physicians there was general dissatisfaction with current efforts to provide medical care for those receiving assistance from welfare agencies.

Physicians estimated that about one-third of their professional services were rendered without compensation. About 30 percent asserted that the number of indigent persons treated was such that their ability to earn a livelihood had been definitely impaired during the previous five-year period.

The changes recommended in present provisions for care of the indigent included a reduction of "red tape", the establishment of a fee schedule, a direct compensation by welfare agencies to physicians, and greater participation by county medical societies.

Experiences with programs for care of the indigent in West Virginia and Pennsylvania were reported to be reasonably satisfactory.

Experiences with medical service systems in industries in Allegany and Garrett counties were said to be fairly satisfactory.

Approximately 76 percent of physicians favored the adoption of a well-controlled plan for public payment for medical care for those on relief. About one-quarter of these also favored a plan for those in the low income brackets. Fourteen percent were satisfied with existing conditions. Ten percent were non-committal.

All practitioners agreed that any plan which might be developed should provide for freedom of choice of physician.

Opinions were about equally divided between those who favored full or reduced fees under such a plan.

The majority of physicians were of the opinion that a public payment plan could best be administered locally by the county health department in collaboration with the county medical society. While a State agency, in coordination with the Medical and Chirurgical Faculty of Maryland, might formulate general policies, it seemed essential, in their opinion, to provide for a certain amount of local autonomy to solve specific local problems.

Chapter IV

NURSES' SERVICES

Distribution of Nurses

In 1941, a total of 1,143 active registered nurses was located in the counties of Maryland, according to the National Survey of Registered Nurses made by the U. S. Public Health Service in cooperation with the National and State Nurses Association. In Table 20, page 21, their distribution is shown by color and sex, as well as the nurse: population ratio. It will be noted that 1,119 or 98 percent, were white females, while 13 white males and 11 colored female nurses comprised the remaining 2 percent. The largest number of nurses, 195, was found in Montgomery, and the smallest, 4, in Garrett County. The highest nurse: population ratio, 1:376, was noted in Talbot, and the lowest, 1:5,495, in Garrett County.

In Table 20, page 21, it also will be observed that, in general, the highest relative number of active registered nurses was located in those counties which have been classified in the higher economic level.

TABLE 20

ACTIVE REGISTERED NURSES IN MARYLAND IN 1941 BY RACE, SEX AND THE NURSE: POPULATION RATIO*

	Total	White		Colored Female	Nurse: Population Ratio
		Male	Female		
State of Maryland	3,187	17	3,112	58	1: 571
Baltimore City	2,044	4	1,993	47	1: 420
Total Counties	1,143	13	1,119	11	1: 842
Talbot	50		49	1	1: 376
Montgomery	195	4	191		1: 430
Wicomico	69		68	1	1: 500
Allegany	132	1	131		1: 658
Prince George's	108		106	2	1: 829
Washington	82		82		1: 839
Baltimore	184	8	176		1: 847
Anne Arundel	79		78	1	1: 866
Dorchester	31		31		1: 903
Frederick	59		59		1: 971
Cecil	27		26	1	1: 978
Kent	12		11	1	1:1,122
Harford	26		26		1:1,348
Howard	12		11	1	1:1,431
Queen Anne's	10		10		1:1,448
Calvert	6		5	1	1:1,747
Caroline	10		10		1:1,755
Carroll	18		16	2	1:2,170
Somerset	9		9		1:2,329
Saint Mary's	6		6		1:2,438
Charles	7		7		1:2,516
Worcester	7		7		1:3,035
Garrett	4		4		1:5,495

*National Survey of Registered Nurses made by the U. S. Public Health Service in cooperation with the National and State Nursing Associations.

Types of Nursing Service

In Table 21, page 21, the number of active *female* registered nurses in private duty and in other types of nursing has been indicated by the counties in which they were located in the year 1941. Of the total of 1,130 in all counties, 412 were in private duty, 457 were employed in hospitals or other institutions, 144 were in public health, 46 in industrial nursing, while 71 were engaged in other limited types of nursing.

In Table 22, page 22, the percent of registered nurses in private duty and in limited categories have been shown for the State of Maryland. In the total counties 36.5 percent of nurses were in private duty, 40.4 percent were in institutional nursing, 12.7 percent in public health, 4.1 percent in industrial nursing and 6.3 percent in other limited types, in striking similarity with the percentages in Baltimore City.

In 1940 in the counties of Maryland, there were no public organizations of nurses engaged in bedside service.

TABLE 21

ACTIVE FEMALE REGISTERED NURSES AND LIMITED TYPES OF NURSING IN THE STATE OF MARYLAND IN 1941*

	Total	Private Duty	Hospital or other Institution	Public Health	Industrial	Others
State of Maryland	3,170	1,283	1,322	336	115	114
Baltimore City	2,040	871	865	192	69	43
Total Counties	1,130	412	457	144	46	71
Allegany	131	73	30	10	9	9
Anne Arundel	79	27	32	18	1	1
Baltimore	176	52	84	25	10	5
Calvert	6	3	1	2		
Caroline	10	5	3	2		
Carroll	18	3	9	4		2
Cecil	27	8	12	3	2	2
Charles	7	1	3	2		1
Dorchester	31	18	11	2		
Frederick	59	15	29	7	2	6
Garrett	4	1	1	2		
Harford	26	12	9	3	2	
Howard	12	4	5	3		
Kent	12	3	3	4	1	1
Montgomery	191	60	68	23	13	27
Prince George's	108	16	69	10	4	9
Queen Anne's	10	3	3	3		1
Saint Mary's	6	1	2	3		
Somerset	9		5	3		1
Talbot	50	33	15	1		1
Washington	82	39	38	4	1	
Wicomico	69	33	25	5	1	5
Worcester	7	2		5		

*National Registry of Registered Nurses.

The unexpected termination of field activities made it necessary to omit a detailed study of nursing care in the counties which had been projected. References to various aspects of this subject, however, have been made in other Chapters of this report. For example, in Chapter III it was pointed out that, outside the medical centers, there were relatively few graduate nurses available for home nursing, because, it was asserted, very few persons were able to pay the cost. In such areas, "practical" nurses were found in larger numbers than in the cities. The opinion was advanced by physicians that practical nurses should be encouraged to become located in these rural areas, which comprise a large part of the State. It also was suggested that practical nurses should be urged, and even required, to take training in the more simple of the standard nursing procedures. This suggestion is one which might well be given serious consideration by those in authority in the field of nursing. It might also be included among the subjects for possible future study by the Committee on Medical Care.

TABLE 22

PERCENT OF FEMALE REGISTERED NURSES BY GENERAL AND SPECIAL TYPES OF NURSING IN MARYLAND IN 1941

	Total	Private Duty	Institution	Public Health	Industrial	Other
State of Maryland	3,170	40.5	41.7	10.6	3.6	3.6
Baltimore City	2,040	42.7	42.4	9.4	3.4	2.1
Total Counties	1,130	36.5	40.4	12.7	4.1	6.3

In Chapter VI, brief reference is made to institutional nursing, while in Chapter VII the activities of public health nurses are outlined. In Chapter VIII, it will be noted that the county welfare executives asserted that the services of a registered nurse rarely, if ever, could be obtained for those receiving relief because of the cost. These officials also urged that a bedside nursing service be organized for indigent patients.

Summary

In 1941, a total of 1,143 active registered nurses was located in the counties. Of these, 1,119, or 98.0 percent were white females, while 13 white males and 11 colored females comprised the remaining 2 percent.

The highest relative number of graduate nurses was located in the counties in the higher economic level.

Of the 1,130 active female registered nurses, there were 412, or 36.6 percent in private duty; 457, or 40.4 percent in institutions; 144, or 12.7 percent, in public health; 46, or 4.1 percent, in industrial nursing; and 71, or 6.3 percent, in other limited types of service. There were no organized public visiting nurses in the counties.

The suggestions have been reiterated that practical nurses be encouraged to locate in the rural areas and that those now at work should be urged to take limited training. Reference was also made to the suggestion of county welfare executives that visiting nurses be organized to render bedside nursing in the homes of those receiving assistance.

Chapter V

DENTISTS' SERVICES[1]

A SURVEY OF THE DENTAL SERVICES in the counties of Maryland was based upon a study of the distribution of private and public dental facilities and consultations with dentists in private practice and with State and county health officials.

Distribution of Dentists

In Table 23, page 23, the number of dentists is shown by counties with the number of persons per dentist in each. It will be seen that a total of 295 dentists was in active practice in 1940. The dentist: population ratio varied between 1:2,025 in Washington County and 1:8,588 in Howard County with 1:7,001 in Dorchester County. The latter probably is the more significant ratio, since Howard County adjoins Baltimore City and many county residents undoubtedly obtain dental treatment in that center.

Committees of the American Dental Association, the U. S. Public Health Service and other professional groups have developed dentist: population ratios desirable for "adequate" dental care: (i) during "normal" conditions, 1:1,000, and (ii) during emergencies; 1:2,500. The first ratio implied adequate dental care for each 1,000 potential patients—generally assumed to mean 60 percent of needed dental service per individual. The second ratio connotes complete dental care for some, adequate service for others and emergency care *only* for the remainder of the 2,500 patients.

If these formulae are compared with those which existed in the counties of Maryland in 1940, it is found that no county even approximated the ratio of 1:1,000—the nearest being Washington County with 1:2,025—and the first 7 counties listed in Table 23 exceeded or approximated the 1:2,500 ratio.

The need for additional dentists appeared to be greatest in Calvert, Queen Anne's, St. Mary's, Garrett, Charles and Dorchester counties.

The proximity of Baltimore, Howard and Prince George's counties to Baltimore and the District of Columbia undoubtedly explain, in part, the relatively low dentist: population ratios in these counties. On the other hand, while suburban residents usually have comparatively easy access to dental services in the cities, it was observed in each of these counties that there were large sections in which dentists rarely were found—places in which such services were sorely needed.

It is obvious that the dentist: population ratios for the counties of Maryland are not always comparable, as was observed in discussing the physician: population ratios—and for practically the same reasons. At best, such ratios serve only in a *general* way to indicate the distribution of dentists in a given population.

TABLE 23

DISTRIBUTION OF DENTISTS IN ACTIVE PRACTICE IN THE STATE OF MARYLAND, BALTIMORE CITY AND IN THE COUNTIES OF MARYLAND IN 1940, TOGETHER WITH THE TOTAL POPULATION AND THE DENTIST: POPULATION RATIO

	Total Dentists in Active Practice (1940)	Total Population (1940)	Dentist: Population Ratio
State of Maryland	862	1,821,244	1:2,113
Baltimore City	567	859,100	1:1,515
Total Counties	295	962,144	1:3,262
Washington	34	68,838	1:2,025
Frederick	28	57,312	1:2,047
Worcester	10	21,245	1:2,125
Montgomery	35	83,912	1:2,397
Allegany	35	86,793	1:2,480
Carroll	15	39,054	1:2,604
Harford	13	35,060	1:2,697
Cecil	8	26,407	1:3,301
Kent	4	13,465	1:3,366
Wicomico	10	34,530	1:3,453
Somerset	6	20,965	1:3,494
Caroline	5	17,549	1:3,510
Baltimore	38	155,825	1:4,101
Talbot	4	18,784	1:4,696
Queen Anne's	3	14,476	1:4,825
Saint Mary's	3	14,626	1:4,875
Anne Arundel	14	68,375	1:4,884
Prince George's	17	89,490	1:5,264
Garrett	4	21,981	1:5,495
Charles	3	17,612	1:5,871
Dorchester	4	28,006	1:7,001
Howard	2	17,175	1:8,588
Calvert	*	10,484	*

*One dentist in part-time practice.

In Table 23, page 23, it will be observed that the dentist: population ratio, like that of physicians and nurses, was, in general, higher in the counties in the higher economic level, and lower in the remaining counties. If this concentration of dentists in the more wealthy counties has been developing for a number of years, as was found with physicians, the proportion of those requiring dental care in the less fortunate areas has been increasing from year to year.

[1]For much of the basic material in this chapter the Committee is indebted to Richard C. Leonard, D.D.S., Chief, Division of Oral Hygiene, Maryland State Department of Health. The names and addresses of dentists in practice in the counties were provided by H. B. McCarthy, D.D.S., Professor of Dental Anatomy, University of Maryland.

Dental Care Among Negroes

The Negro population presents another specific problem in dental care. In the 23 counties of Maryland there was a total of 136,368 Negroes, according to the U. S. Census of 1940. In the same year there were only seven Negro dentists located in four counties—Anne Arundel, Frederick, Prince George's and Wicomico. If all Negroes were treated by colored dentists, the dentist: Negro population ratio would be 1:19,481. The number of Negroes obtaining treatment from white dentists probably is not sufficient to change this ratio significantly, or to lessen the magnitude of the problem.

Public Dental Services

For many years before the inauguration of a State-wide oral hygiene program, dental clinics for treatment of the indigent were conducted by dentists in several counties of Maryland. In most, if not all of these clinics the practitioners served on a voluntary basis and at considerable personal sacrifice. These volunteer activities were the foundation stones upon which the modern oral hygiene program was built.

In 1929, a law[1] was amended by the State legislature to provide for the addition of "an experienced dental surgeon" to the membership of the State Board of Health. On September 26, 1929, the latter established a Division of Oral Hygiene and appointed a Division Chief.

The State Oral Hygiene Program

The State oral hygiene program has been primarily educational, enlightening the public in general, undergraduates in dentistry, teachers-in-training and school children in particular, in the ways and means of maintaining mouth health.

School dental clinics for the first three grades, ages 6, 7 and 8 years, were established in public and parochial schools. Efforts were made to limit examination and treatment to children of indigent parents. In the absence of investigating facilities, however, it was found more satisfactory, with the consent of local dental practitioners, to treat every child in the limited age group without regard to financial status.

The clinics varied in character. Some of the clinicians were full-time salaried dentists, as in Allegany, Montgomery and Washington counties; in other counties, local practitioners devoted half time or less on a *per diem* salary as in Anne Arundel, Baltimore, Calvert, Charles, Frederick, Harford, Carroll, Howard, Kent, Prince George's, Queen Anne's, Talbot, Wicomico and Worcester counties.

In Garrett County an experiment was conducted, with more or less success, in which a group of dentists agreed to treat all school children in their offices. Another unusual feature of the Maryland program in recent years was the use of the Healthmobile, an itinerant bus which brought medical and dental inspection plus emergency dental treatment to pre-school and school children. In the Healthmobile service, five dental clinicians devoted part-time for four months each summer in Calvert, Caroline, Charles, Cecil, Kent, Prince George's, Queen Anne's, St. Mary's, Somerset and Worcester counties.

Some county dental clinics provided entirely free service only to children of indigent parents, others gave free and low cost service, the latter at a flat rate per child.

In all counties the dentists either served on the staff of the county health department or functioned in close cooperation with the county health officer and public health nurses.

Few of the counties had an adequate school dental service. There were no organized dental services, with the exception of the very limited Healthmobile activities, in Caroline, Cecil, Dorchester and St. Mary's counties. The number of children examined and treated in the school dental clinic, with the total operations in the years 1930 and 1940 were as follows:

Year	Children Examined	Children Treated	Percent Treated	Total Operations*	Operations Per Child
1930	14,945	7,606	50.9	21,532	2.8
1940	30,052	12,461	41.5	46,868	3.8

*Total operations included all fillings, extractions and treatments.

In the ten-year period, 1930-40, it will be noted that the number of children attending clinics has approximately doubled. The percent of those treated in the school clinics has somewhat decreased; and the operations per child have increased from 2.8 to 3.8 per child. It is probable that a fairly large, but as yet undetermined number of children examined in the clinics were treated in the offices of private dentists.

In Table 24, page 26, the distribution of the school dental clinic services in the counties of Maryland in 1940 is shown. In 2,263 clinic sessions in all counties there were 30,052 children examined and 12,461 treated. Operations totalled 51,563 of which there were 26,794 fillings, 15,974 extractions, 4,636 prophylactic and 4,159 other treatments.

Cost of Clinics

For the year 1940, the total dental clinic expenditures was $19,801. Of this amount $4,063 was received from the State and/or Federal Government; $9,396 from county and city governments; $3,683 from local organizations, chiefly Parent-Teacher Associations; and $2,659 from clinic fees.

[1]Article 43, Section 1, Annotated Code of Maryland, 1929.

The work was continued only so long as funds were available. Deficits in State or local funds were carefully avoided.

As a result of the relatively small appropriations for dental clinics, particularly by the State of Maryland, very limited amounts could be granted to each clinic. It was practically impossible to set up a dental clinic service without substantial aid from local authorities. In the counties in the lower economic levels full-time dental services could not be provided. Furthermore, it was not possible, except in rare instances, to offer sufficient salaries to young graduates to induce them to adopt this type of service as a career.

It is obvious that the oral hygiene program has been seriously handicapped by inadequate appropriations. It is also clear that a great deal has been accomplished with very little. Unfortunately, however, the figures available indicate that only a beginning has been made in providing dental care for school children, and that the treatment of indigent adults has received little or no attention.

Programs for Dental Care for the Indigent

Dental care for the indigent is a problem of such magnitude that it would be advantageous, according to dental authorities, to divide the potential patients into age groups and provide, so far as possible, the most appropriate types of treatment for each group. The need for at least two divisions of the population is indicated for (1) pre-school and school children, and (2) adolescents and adults.

1. *A Program for Pre-School and School Children*

On account of its potentially enduring effect, the treatment of pre-school and school children should be as complete and long continued as possible.

It seems logical that a program for dental care for these age groups should be centered around a school dental clinic. Indeed, this has been found by experience to be the method of choice. It is taken for granted that clinics should be established in both public and parochial schools. In all school clinics opportunities should be provided for as much care for pre-school children as is practicable.

Treatment in school clinics should not be confined to emergency types alone—on the contrary, such prophylactic measures as are of proven value should be used as a matter of routine. It has been asserted that preventive, in contrast to "restorative" treatment, can be made available to a larger proportion of the population in a given time—and at much less cost.

This program for pre-school and school children would require the services of at least one full-time dentist in each county in Maryland. In the past it has been found decidedly advantageous to have school dentists attached to the staff of the county health departments.

2. *A Program for Adolescents and Adults*

For economic reasons, the care of adolescents and adults, in the opinion of competent dental authorities, must be limited to less than complete treatment. Certainly the relief of pain should be possible and, so far as practicable, the restoration of part normality of dental function.

For the treatment of adolescents and adults, clinics need not be established where reasonably adequate service may be rendered by private practitioners without seriously affecting the dentist: population among those able to pay for dental care.

In the counties having the highest numbers of dentally indigent, at least one full-time dentist for treatment of adults, in addition to the school dentist, should be employed. In counties in which the number of dentally indigent is not so great, it is believed that an additional dentist should be employed for treatment of adults until the school dental program has become well established. When this has been accomplished, the services of the additional dentist might be discontinued or the practitioner transferred elsewhere. In counties with a relatively small number of dentally indigent, it is felt that one full-time dentist might be able to conduct both programs. In all cases, the dentists should serve as members of the staff of the county health department.

Comments on Determination of Eligibility

In discussing the question with dentists in various parts of the State, it has been emphasized repeatedly that the criteria for determining eligibility for free or part-pay dental care should be identical with those for medical treatment.

Local Administrative Representation

In counties in which corrective clinics are necessary, it has been stressed that it is important that they should be established with the full cooperation of the local dentists. To this end, it has been suggested by a number of dental practitioners that a representative of the county dental society should be included in any county organization that subsequently may be established for the administration of medical care and dental care.

Essential Steps

In order to secure a more equitable distribution of dental facilities, the following steps appear to be indicated:

(a) Provide ways and means of encouraging young graduates in dentistry to practice in the counties in the lower economic levels.

(b) Increase appropriations so that the school dental clinics may be expanded.

(c) Provide dental treatment of indigent adults.

(d) Intensify public education in the value of dental health, and in the advantages of early and continued observation and treatment.

Summary

A total of 295 dentists was in active practice in the 23 counties of Maryland in 1940.

In no county did the dentist: population ratio equal that regarded as adequate for normal conditions, namely: 1:1,000. In Washington, Frederick, Worcester, Montgomery, Allegany, Carroll and Harford counties the ratios approximated that considered adequate *only* during emergencies, 1:2,500. Using these ratios as criteria, the distribution of dentists in other counties appeared quite inadequate.

The need for additional dentists appeared to be greatest in Calvert, Charles, Garrett, St. Mary's and Queen Anne's counties.

It seems evident that dentists have become more concentrated in counties in the *higher* economic levels, with the result that the need for dental care has increased significantly in the counties in the *lower* economic levels.

The dentist: Negro population ratio was 1:19,481.

For the year 1940, expenditures for oral hygiene totalled $19,801. The program has been seriously handicapped by inadequate appropriations.

Outlines of programs for the care of the dentally indigent have been presented, including (1) a program for pre-school and school children, and (2) a program for adolescents and adults.

In general, a minimum of one full-time dentist for each of these programs would be required in each county in the State, with these practitioners serving on the staff of the county health departments.

It has been suggested that the criteria for determining eligibility for free or part-pay dental care should be identical with those for medical treatment.

It was also suggested that a representative of each county dental society should be included in any county organization which may subsequently be established for the administration of medical and dental care for the indigent and medically indigent.

The following steps are deemed essential to obtain a better distribution of dental care:

1. Assist young graduates to become established in the counties with the largest proportions of dentally indigent.
2. Provide appropriations for expansion of school dental programs and establishment of clinics for treatment of dentally indigent.
3. Intensify education in the importance of dental health.

TABLE 24

SCHOOL DENTAL CLINICS CONDUCTED IN THE COUNTIES OF MARYLAND, 1940

Co.	Number of Clinics	Number of Children		Operations				
		Examined	Treated	Fillings Inserted	Teeth Extracted	Prophy-lactic Treat.	Other Treat.	Total
Allegany	283	3,460	1,690	1,076	3,727	575	1,397	6,775
Anne Arundel	243	3,827	1,515	3,328	1,461	654	109	5,552
Baltimore	323	7,396	1,627	3,734	1,557	856	651	6,798
Calvert	29	528	323	844	389	10	22	1,265
Charles	32	293	131	417	173	72	0	662
Frederick	129	1,284	1,112	1,728	1,061	63	1	2,853
Garrett	7	66	47	79	166	2	1	248
Harford	39	723	704	1,681	885	634	20	3,012
Howard	80	856	236	893	437	177	125	1,632
Kent	70	730	343	1,581	494	157	7	2,239
Montgomery	179	1,475	1,191	3,007	1,478	426	69	5,188
Prince George's	132	1,364	867	1,822	698	77	173	2,770
Queen Anne's	78	729	204	582	251	145	21	999
St. Mary's	*			18	30	0	0	48
Talbot	73	1,249	210	419	138	210	60	827
Washington	282	1,779	1,034	2,634	1,587	391	132	4,744
Wicomico	37	427	122	153	251	70	34	472
Worcester	177	2,355	575	2,123	859	101	775	3,838
Healthmobile	** 70	1,511	530	675	368	16	582	1,641
Total	2,263	30,052	12,461	26,794	15,974	4,636	4,159	51,563

*No special clinic days set aside—work done in private dental offices.

**In Healthmobile service, five dental clinicians devoted part-time for four months in the following counties: Calvert, Caroline, Cecil, Charles, Kent, Prince George's, Queen Anne's, St. Mary's, Somerset and Worcester.

Chapter VI

GENERAL HOSPITALS

Distribution

In 1940 there was a total of 18 general hospitals[1] in the counties of Maryland. Thirteen counties had one hospital each, while Allegany had 3 and Frederick County 2. The following 8 counties were without hospitals: Baltimore, Carroll, Caroline, Garrett, Howard, Prince George's, Queen Anne's and Worcester.

With respect to bed capacity, excluding bassinets, the 18 hospitals may be divided into 3 groups.

1. *More than 100 beds*

Name	Location	Total Beds
Peninsula General	Salisbury	177
Memorial	Cumberland	160
Washington County	Hagerstown	142
Frederick City	Frederick	112
Emergency	Easton	109
Allegany County	Cumberland	105

2. *From 50-99 beds*

Annapolis Emergency	Annapolis	85
Cambridge-Maryland	Cambridge	85
Emergency	Frederick	50

3. *Less than 50 beds*

Union Hospital of Cecil County	Elkton	45
Harford Memorial	Havre de Grace	42
Montgomery County	Olney	40
Miners	Frostburg	39
E. W. McCready Memorial	Crisfield	35
St. Mary's	Leonardtown	32
Kent and Upper Queen Anne's	Chestertown	25
Physicians' Memorial	La Plata	25
Calvert County	Prince Frederick	23

In Table 25, page 28, hospitals have been listed with the number of beds in order of the hospital bed: population ratio for each county. The number of beds in all hospitals was 1,331 and the bed capacity ranged from 177 in Peninsula General to 23 in Calvert County Hospital. It will be noted that the hospital bed: population ratio for the counties in which the institutions were located varied from 1:172 in Talbot County to 1:2,098 in Montgomery County.

A ratio of 4.5 hospital beds per 1,000 population, or 1 hospital bed for every 222 persons, is regarded by some authorities as a suitable standard of adequacy. In Table 25, it will be observed that Talbot and Wicomico are the only counties in which the relative bed capacity exceeds that ratio, although Allegany County closely approximates it. In the counties of Maryland, however, too much dependence can not be placed upon the utilization of this ratio for the following reasons:

1. Hospitals in several counties serve either the whole or a part of adjacent counties.
2. Residents of every county in the State were admitted to hospitals in Baltimore City and, less frequently, to those in the District of Columbia and in the neighboring States, Pennsylvania, West Virginia and Delaware.

Ownership and Administration

Fifteen hospitals were owned by non-profit corporations, and the business of each was administered by a board of directors with a superintendent appointed by that body. There were three hospitals—Miners, Frederick Emergency and Allegany County—which were organized upon different lines:

1. Miners Hospital in Frostburg was owned and operated by the State of Maryland, its Board of Managers appointed by the Governor of the State, and the financial transactions were conducted through the office of the State Comptroller in Annapolis.
2. The Frederick Emergency Hospital was owned and operated by the County Commissioners of Frederick County. This was the only hospital maintained solely for the indigent.
3. Allegany County Hospital was owned by the Catholic Sisters of Charity and, at the time of the survey, its Board of Directors were four members of that Sisterhood.

Board of Directors

The impression was gained that each board of directors was composed of men and women who, as a rule, gave generously of their time and talents in promoting the welfare of the hospital which they served. In the majority of institutions, however, the board appeared to be a closed, self-perpetuating body, since replacements were usually made in accordance with the desires of those remaining on the board. In only a very small proportion of the hospitals was it evident that membership was fully representative of and open to the community as a whole.

Superintendents

In fourteen hospitals the superintendents were graduate nurses, while in the three largest—Peninsula General, Memorial (Cumberland) and Washington County, laymen, with experience in hospital administration, served in that capacity. In Calvert County a member of the medical staff also served as the superintendent.

[1] In this chapter, and elsewhere in this report, the term "hospital" connotes *general* hospital—unless otherwise qualified.

In the majority of institutions the superintendent participated in the meetings of the board of directors and, less frequently, in the deliberations of the medical staff. In one or two of the smaller hospitals the superintendent not only transacted the business of the institution but functioned as superintendent of nurses, dietitian, anesthetist or even as clerk.

Ladies' Auxiliaries

Nearly every hospital had a ladies' auxiliary or similar organization which performed the very useful function of providing supplies and equipment which added to the comfort and well-being of patients. Some of these auxiliaries extended their activities still farther, contributing quite large sums each year toward the maintenance of the institution by conducting fairs, sales, and maintaining other sources of revenue.

The Medical Staff

For appointment to the medical staff a physician was obliged, as a rule, to present a written application giving his training and experience. If membership requirements were fulfilled, the application was approved and sent to the board of directors for ratification. In the larger institutions, a probationary period of one year was necessary before full staff privileges were granted. In the meantime courtesy privileges were extended.

In most hospitals medical staff meetings were held each month to discuss clinical and other matters having to do with the medical management of the institution. In some hospitals the activities of the staff were even more comprehensive. For example, in Washington County Hospital, in addition to the usual monthly meetings, clinics and symposia were held each Sunday morning throughout the year. As a rule, a physician or surgeon from a larger medical center was the guest clinician or lecturer. The attendance

TABLE 25

DISTRIBUTION OF GENERAL HOSPITALS IN THE COUNTIES OF MARYLAND IN 1940, TOGETHER WITH THEIR BED CAPACITY (EXCLUDING BASSINETS) AND THE HOSPITAL-BED: POPULATION FOR THE COUNTY IN WHICH THE INSTITUTION WAS LOCATED.

County	Name of Hospital	Location	Total Beds	Hospital Bed: Population Ratio
Talbot	Emergency Hospital	Easton	109	1: 172
Wicomico	Peninsula General Hospital	Salisbury	177	1: 195
Allegany	Allegany County Hospital	Cumberland	105	1: 286
	Memorial Hospital	Cumberland	160	
	Miners Hospital	Frostburg	39	
Dorchester	Cambridge-Maryland Hospital	Cambridge	85	1: 329
Frederick	Emergency Hospital	Frederick	50	1: 354
	Frederick City Hospital	Frederick	112	
Calvert	Calvert County Hospital	Prince Frederick	23	1: 456
St. Mary's	St. Mary's Hospital	Leonardtown	32	1: 457
Washington	Washington County Hospital	Hagerstown	142	1: 485
Kent	Kent and Upper Queen Anne's General Hospital	Chestertown	25	1: 539
Cecil	Union Hospital of Cecil County	Elkton	45	1: 587
Somerset	E. W. McCready Memorial Hospital	Crisfield	35	1: 599
Charles	Physicians Memorial Hospital	La Plata	25	1: 704
Anne Arundel	Annapolis Emergency Hospital	Annapolis	85	1: 804
Harford	Harford Memorial Hospital	Havre de Grace	42	1: 835
Montgomery	Montgomery County General Hospital	Olney	40	1:2,098
	Total		1,331	1: 723*

*Hospital bed: population for total counties.

was uniformly high. In this manner the staff were assisted in keeping abreast of progress in medicine.

In the larger hospitals, medical, surgical, obstetrical, pediatric and accident departments have been organized, with a physician or surgeon in charge of each.

Residents and Internes

In Montgomery County General, Easton Emergency and Peninsula General Hospitals, resident physicians were employed. In Allegany County, Memorial (Cumberland) and Annapolis Emergency Hospitals, "summer" internes were in residence whenever they could be obtained. In other hospitals, members of the staff were assigned in rotation to ward and emergency services.

In each hospital in which residents or internes were employed, the superintendent expressed deep appreciation of their work. Medical records were well organized, histories were complete; progress notes were up to date; physicians' services were immediately available day or night. In institutions in which residents or internes were *not* employed the need for such services was all too apparent.

The Nursing Staff

The number of graduate nurses employed by hospitals varied widely. In Frederick City Hospital thirty were on the nursing staff, while in Frederick Emergency Hospital only one graduate was on duty.

Training schools for nurses were conducted in Allegany County, Memorial (Cumberland), Easton Emergency, Frederick City, Washington County and Peninsula General hospitals.

In some of the smaller hospitals nurse-assistants were employed. In Calvert County, Union Hospital of Cecil County and in the Harford Memorial hospitals, nurses of this type constituted the majority of the nursing staff.

In most hospitals the quarters provided for nurses were adequate and comfortable. In larger institutions a separate building was used. In smaller hospitals nurses usually resided at home, or occupied rooms in the institutions.

Other Members of Staff

Pharmacists, dietitians, X-ray and laboratory technicians and physio-therapists were, as a rule, employed by hospitals of 100 beds or larger. In smaller institutions one person sometimes functioned in more than one of these capacities.

Departments and Services

1. *Surgery*

All but four hospitals had modern operating rooms and equipment. In a few institutions the surgical departments appeared unnecessarily elaborate in striking contrast to equipment in other services. As a rule, a graduate nurse, with special training, was in charge of the operating room, with a staff of graduates and undergraduates. In some hospitals, nurses assisted at operations. In most institutions, the recording of preoperative diagnoses and operative techniques and findings appeared to be well-established routines.

2. *Anesthesia*

Well-equipped departments of anesthesia were found in all the larger institutions. Quite commonly graduate nurses with special training served as anesthetists. In the smaller hospitals, the attending physician usually administered anesthetics.

In the larger hospitals, a routine physical examination was made shortly before the induction of anesthesia. In several of the smaller institutions it was said that the examination, as a rule, was made by the attending physician usually *before* the patient was hospitalized.

3. *Emergency Services.*

Almost all of the hospitals had a well-equipped emergency service. In four of the smaller institutions: Calvert County, Physicians Memorial, Harford Memorial and in St. Mary's hospitals, this service was not regarded as adequate.

Hospital care of accident cases was a major problem of superintendents. Many patients treated in the accident room were not admitted to the hospital, but if hospitalization were necessary, it was usually prolonged, costly, and a high proportion of individuals was unable to pay its expenses. In those hospitals near main arteries of traffic, the ever-increasing number of highway accidents not infrequently overtaxed the capacity and resources of the institution.

4. *Outpatient Departments.*

Except for emergency service in accident rooms, none of the hospitals operated outpatient departments, although in Easton Emergency Hospital facilities were being added in which treatment of patients after discharge from the hospital was planned. In Washington County Hospital an excellent outpatient department was constructed, but the facilities have not been used for that purpose.

In Memorial (Cumberland), Cambridge-Maryland, Harford Memorial, Montgomery County General, Washington County and Peninsula General hospitals, space for clinics conducted by the county health departments was provided, either in the hospital proper or in a building on the hospital grounds. In several hospitals, certain types of patients were referred to these clinics for further observation or treatment after discharge from the hospital.

5. *Obstetrics.*

Almost invariably obstetrical departments were supervised by well-trained nurses and provided with reasonably adequate equipment. In most instances an isolation unit for mothers and the new born was available.

6. *Clinical Laboratories.*

In all except Calvert County, Frederick Emergency, Kent and Upper Queen Anne's, and St. Mary's hospitals, a laboratory was maintained for such routine tests as urinalysis, blood counts, estimations of coagulation time and other relatively simple procedures. In most institutions, especially those of more than 100 beds, a fairly complete laboratory service was provided.

At the Physicians Memorial Hospital, a bacteriologist employed by the State Department of Health directed a *combined* public health and clinical laboratory. It was planned that this service would also be extended to include St. Mary's and Calvert County hospitals, the bacteriologist's time being divided between three institutions, with an assistant bacteriologist working full time in each. This plan was inaugurated on the recommendation of the Committee on Medical Care as the result of a special study.

In Washington County Hospital a full-time pathologist was in charge of a well-equipped bacteriological and pathological laboratory, while in Peninsula General Hospital a full-time bacteriologist and a part-time pathologist were employed. Wasserman tests or modifications of this technique were made routinely in Washington County and in Peninsula General hospitals. In all others, specimens of blood and spinal fluid for syphilis serology were sent to laboratories of the State Department of Health in Baltimore or Cumberland.

7. *X-ray.*

All of the hospitals except Frederick Emergency owned and operated diagnostic X-ray machines. In Memorial Hospital (Cumberland), Annapolis Emergency, Peninsula General and Washington County Hospitals, a physician, experienced in Roentgenology, was in charge of the X-ray department. In most of the remaining institutions, technicians were employed to make exposures and develop films while readings generally were made by the attending physician, a member of the staff with special training in this type of work. In some hospitals the films were interpreted by authorities in Baltimore or elsewhere.

Deep therapy X-ray equipment was installed in the Memorial Hospital (Cumberland), the only hospital which possessed this type of equipment.

8. *Dietetics*

All of the larger and a few of the smaller hospitals had a Department of Dietetics under the supervision of a trained dietitian. A nurse or cook was in charge of the diet kitchen in other institutions.

9. *Pharmacies and Drug Rooms*

A pharmacist was employed in Allegany County, Memorial Hospital (Cumberland), Frederick City, Easton Emergency and Washington County hospitals, while in other institutions the drug room was in charge of a graduate nurse.

10. *Physiotherapy*

The Memorial Hospital in Cumberland was the only hospital which had a Department of Physiotherapy.

11. *Medical Social Service*

None of the county hospitals maintained a medical social service department. In larger hospitals the need for such a service was indicated. In several institutions, public health nurses or welfare department workers were pressed into service in emergencies. In the smaller hospitals there was not a sufficient demand for medical social service work to justify the employment of a trained person.

12. *Medical Records*

The larger hospitals maintained a well-organized medical record room. Except in hospitals employing resident physicians, however, this activity was a constant source of concern to hospital administrators.

The attending physician, as a rule, was held responsible for writing histories and keeping progress notes up to date. In a few hospitals stenographic assistance was provided. Some physicians, presumably because of a lack of time, permitted large numbers of incomplete histories to accumulate. Various schemes were employed by hospitals to induce doctors to complete case records within a reasonable time after discharge of the patient.

Allegany County, Memorial Hospital (Cumberland), Easton Emergency, Montgomery General and Peninsula General hospitals were listed as institutions in which records were maintained in a satisfactory manner.

In some of the smaller hospitals the histories were usually very brief, progress notes were often omitted, and the records which rarely were indexed, were stored in inaccessible and unsafe places.

13. *Ambulance Service*

Easton Emergency and Harford Memorial were the only hospitals operating an ambulance service.

In several counties it was customary for the families, or agency which assumed responsibility for care of the patient, to negotiate with ambulance owners, usually funeral directors. In other counties local authorities, such as health departments, depended upon the Maryland State

Police who operated nine ambulances from sub-stations in various parts of the State, and rendered constant, valuable service. In several counties automobiles of public health nurses and welfare workers were not infrequently used for transportation of the sick. In other counties local fire or police departments provided ambulance service. In a few instances, ambulances were maintained by public subscription.

In emergencies, it was declared that in every county it was always possible to find *some one* who was willing to transport a patient to a hospital, even though the distance may be great. Serious delay, however, was sometimes occasioned while arrangements were being completed, since there was no recognized channel, except the State Police, through which ambulance service might be quickly obtained. Furthermore, while some ambulances were well-equipped and even luxurious, other vehicles used for the purpose, particularly the "family car", were quite unsuitable, caused considerable suffering en route and, at times, reduced the patient's chances of recovery or prolonged the period of hospitalization.

To overcome the difficulries which have been mentioned, it is suggested that a State-wide organization be selected to integrate existing ambulance services and supplement them whenever necessary, so that patients may be transported to the hospital safely, comfortably and without undue delay. It would, of course, be necessary to appropriate funds for this coordinating service, but it is believed that the amount need not be large.

In Table 26, page 31, a partial list is presented of the ambulance services in the counties of Maryland in the year 1941, indicating the owners or operators, the number of vehicles and their total capacity.

Types of Construction

Many hospitals, particularly those having a capacity of more than 100 beds, were constructed of stone or brick and were well-equipped institutions of which the community had every right to be proud. In nearly all hospitals there was evidence of sacrifice on the part of local citizens in order to provide the best possible buildings and equipment. Several of the smaller hospirals were converted residences.

Financial Resources

Hospirals derived their chief sources of revenue from patients, interest on investments, bequests and other special gifts, as well as appropriations from State, county and city governments.

With one exception, all hospitals received annual appropriations from the State of Maryland. Frederick Emergency Hospital was maintained solely by the County Commissioners of Frederick County, at a cost, it was said of about $0.60 per patient day.

In 1941, Miners Hospital, owned and maintained by the State of Maryland, was allowed $15,500 from the general fund, $12,500 from a special fund, and $4,705 from the receipts of the institution.

During the fiscal year 1939-40, the amount of $184,795 was allocated by the State to 17 hospitals; and $19,000 to 3 counties for hospitalization of free cases; in addition, $57,038 was appropriated by county and city to 14 hospitals, making a total of $260,833.

TABLE 26

PARTIAL LIST OF AMBULANCE SERVICES IN THE COUNTIES OF MARYLAND IN 1941, INDICATING THE OWNERS OR OPERATORS, THE NUMBER AND TOTAL CAPACITY OF VEHICLES

Area	Owners or Operators	Number of Ambulances	Total Capacity
All Counties	Maryland State Police	9	20
ANNE ARUNDEL			
Annapolis	Fire Department	1	1
Eastport	" "	1	1
West Annapolis	" "	1	1
Brooklyn	" "	1	1
Riviera Beach	" "	1	1
BALTIMORE			
Towson	County Commissioners*	1	3
Catonsville	" "	1	3
Essex	" "	1	3
Sparrows Point	Volunteer Fire Dept.	1	2
Violetville	" " "	1	2
Cockeysville	" " "	1	2
Pikesville	" " "	1	2
Arbutus	" " "	1	2
MONTGOMERY			
Silver Springs	Funeral Directors	3	3
Bethesda	" "	2	2
Rockville	" "	1	1
Damascus	" "	1	1
Gaithersburg	" "	1	1
Barnesville	" "	1	1
PRINCE GEORGE'S			
Glendale	Volunteer Fire Dept.	1	2
Brentwood	" " "	1	2
Bladensburg	" " "	3	6
Branchville	" " "	2	4
Bowie	" " "	1	2
Upper Marlboro	" " "	2	4
Forestville	" " "	1	2
TALBOT			
Easton	Easton Emergency Hospital	1	2
WASHINGTON			
Hagerstown	Community Association	1	2
"	Funeral Directors	3	6
"	Police Department	1	2
WICOMICO			
Salisbury	Red Cross	1	4
"	County Commissioners*	1	4
TOTAL		50	95

*Operated by Fire Department.

TABLE 27

STATE AND LOCAL APPROPRIATIONS TO HOSPITALS IN COUNTIES OF MARYLAND, 1939–40.

County	Name of Hospital	Sources and Total Appropriations (1940)		
		State	County and City	Total
Allegany	Allegany County	$ 14,000	$ 6,000	$ 20,000
	Memorial	17,000	—*	17,000
	Miners	23,295	—	23,295
Anne Arundel	Annapolis Emergency	11,000	1,400	12,400
Calvert	Calvert County	4,000	—	4,000
Cecil	Union Hospital of Cecil County	8,000	6,000	14,000
Charles	Physicians Memorial	2,000	3,500	5,500
Dorchester	Cambridge-Maryland	15,000	4,500	19,500
Frederick	Emergency	—	—	—
	Frederick City	15,000	800	15,800
Harford	Harford Memorial	8,500	6,000	14,500
Kent	Kent and Upper Queen Anne's General	2,500	750	3,250
Montgomery	Montgomery County General	7,500	7,755	15,255
St. Mary's	St. Mary's	3,500	2,333	5,833
Somerset	E. W. McCready Memorial	8,000	750	8,750
Talbot	Easton Emergency	15,500	3,250	18,750
Washington	Washington County	10,000	12,500	22,500
Wicomico	Peninsula General	20,000	1,500	21,500
	Total	$184,795	$57,038	$241,833

*This hospital received financial assistance from the County Commissioners of Allegany County in the form of capital expenditures and maintenance.

TABLE 28

NUMBER AND PERCENT OF PAY AND FREE PATIENTS IN HOSPITALS IN THE COUNTIES OF MARYLAND, 1939-40*

County	Name of Hospital	Total Patients	Pay Patients		Free Patients	
			Number	Percent	Number	Percent
Allegany	Allegany County	3,298	2,175	65.9	1,123	34.1
	Memorial	4,365	2,801	64.2	1,564	35.8
	Miners	—	—	—	—	—
Anne Arundel	Annapolis Emergency	2,213	1,615	73.0	598	27.0
Calvert	Calvert County	576	185	32.1	391	67.9
Cecil	Union of Cecil County	1,279	538	42.1	741	57.9
Charles	Physicians Memorial	448	288	64.3	160	35.7
Dorchester	Cambridge-Maryland	1,226	647	52.8	579	47.2
Frederick	Emergency	—	—	—	—	100.0
	Frederick City	2,063	539	26.1	1,524	73.9
Harford	Harford Memorial	880	339	38.5	541	61.5
Kent	Kent and Upper Queen Anne's	433	292	67.4	141	32.6
Montgomery	Montgomery County General	1,538	926	60.2	612	39.8
St. Mary's	St. Mary's	492	374	76.0	118	24.0
Somerset	E. W. McCready Memorial	611	50	8.2	561	91.8
Talbot	Easton Emergency	2,236	594	26.6	1,642	73.4
Washington	Washington County	3,500	2,593	74.1	907	25.9
Wicomico	Peninsula General	3,180	1,753	55.1	1,427	44.9
	Total	28,338	15,709	55.4	12,629	44.6

*The numbers and percentages of free patients shown here are not comparable between hospitals since there was a lack of uniformity in the interpretation of the term "free patient".

Attempts were made to determine (a) the basis upon which these funds were allocated, and (b) the extent to which they met the cost of hospital care for the indigent.

1. *Allocations of State and Local Funds in 1940*

The amounts of State and local funds allocated to all hospitals in the fiscal year 1939-40 are listed in Table 27, page 32, while the number and percent of pay and free patients and hospital days are shown in Table 28, page 32, and Table 29, page 33, respectively.

During the year under review, the percentage of free cases ranged from 24.0 in St. Mary's County to 91.8 in the E. W. McCready Memorial Hospital as shown in Table 28, page 32. These extremes were both small hospitals. Among the larger institutions, 25.9 percent of patients admitted to Washington County Hospital were free, in contrast with 73.9 percent in Frederick City Hospital.

The percent of free hospital days in the small hospitals varied between 33.1 in St. Mary's and 91.7 in the E. W. McCready Memorial Hospital, as indicated in Table 29, page 33. In the larger institutions the extremes were 31.1 in Washington County and 72.0 in Easton Emergency Hospital.

In accordance with a State law, hospitals should be paid at the rate of $2.50 for each free patient day. In Table 30, page 34, it appears that the amount actually received by the hospitals from the State for each free patient day equals $2.50 only in the case of St. Mary's Hospital. In all other hospitals the amount received was less than $2.50 per free patient day. In the case of Memorial Hospital in Cumberland, it appears to have been as low as $.60 per free patient day but this hospital also received financial aid in the form of capital investments and maintenance from the Allegany County Commissioners.

The amounts received by each hospital from State *and* local sources for each free hospital day, and the estimated cost per patient per hospital day are listed in Table 30. It would appear that appropriations received from State and local sources fell short of compensating the hospitals in amounts varying from $.88 in the case of Montgomery General Hospital to as much as $3.88 per hospital day for Frederick City Hospital. In Physicians Memorial and St. Mary's hospitals amounts received in excess of the cost per hospital day appeared to be $.34 and $.22, respectively. The average difference for 16 hospitals was $1.86 per free hospital day.

Unfortunately, however, so many variations in methods of administration and accounting were observed that the figures can not be considered comparable.

The following differences in administrative practice were observed:

(a) Interpretation of the terms "free case" and "free hospital day" varied widely.

TABLE 29

NUMBER AND PERCENT OF PAY AND FREE HOSPITAL DAYS IN HOSPITALS IN THE COUNTIES OF MARYLAND, 1939-40*

County	Name of Hospital	Total Hospital Days	Pay Days		Free Days	
			Number	Percent	Number	Percent
Allegany	Allegany County	38,007	23,582	62.0	14,425	38.0
	Memorial	49,761	21,218	42.6	28,543	57.4
	Miners	—	—	—	—	—
Anne Arundel	Annapolis Emergency	15,898	10,604	66.7	5,294	33.3
Calvert	Calvert County	5,154	1,475	28.6	3,679	71.4
Cecil	Union of Cecil County	10,825	3,058	28.2	7,767	71.8
Charles	Physicians Memorial	3,843	2,226	57.9	1,617	42.1
Dorchester	Cambridge-Maryland	14,230	6,903	48.5	7,327	51.5
Frederick	Emergency	—	—	—	—	100.0
	Frederick City	21,231	6,636	31.3	14,595	68.7
Harford	Harford Memorial	12,448	4,478	36.0	7,970	64.0
Kent	Kent and Upper Queen Anne's	4,320	2,472	57.2	1,848	42.8
Montgomery	Montgomery County General	14,415	8,360	58.0	6,055	42.0
St. Mary's	St. Mary's	4,110	2,750	66.9	1,360	33.1
Somerset	E. W. McCready Memorial	6,495	542	8.3	5,953	91.7
Talbot	Easton Emergency	23,059	6,445	28.0	16,614	72.0
Washington	Washington County	37,394	25,762	68.9	11,632	31.1
Wicomico	Peninsula General	31,321	15,847	50.6	15,474	49.4
	Total	292,511	142,358	48.7	150,153	51.3

*The numbers and percentages of free hospital days in this table are not comparable, one hospital with the other, since the term "free hospital day" was not uniformly interpreted.

TABLE 30

TOTAL FREE HOSPITAL DAYS, 1939-40, THE AMOUNT RECEIVED PER FREE HOSPITAL DAY FROM STATE AND STATE AND LOCAL SOURCES, TOGETHER WITH THE ESTIMATED COST PER PATIENT PER HOSPITAL DAY

Name of Hospital	Total "Free" Hospital Days (1939-1940)	Amount Received Per "Free" Hospital Day		Cost per Patient per Hospital Day (1939-1940)
		State	State and Local	
Allegany County	14,425	$ .97	$1.39	$3.16
Memorial	28,543	.60	.60**	3.96
Miners	—	—	—	—
Annapolis Emergency	5,294	2.08	2.34	5.19
Calvert County	3,679	1.09	1.09	2.38
Union of Cecil County	7,765	1.03	1.80	3.84
Physicians Memorial	1,617	1.24	3.40	3.06
Cambridge-Maryland Emergency	7,327	2.05	2.66	3.99
	—	—	—	—
Frederick City	14,595	1.03	1.08	4.96
Harford Memorial	7,970	1.07	1.82	2.90
Kent and Upper Queen Anne's	1,848	1.35	1.76	3.40
Montgomery County General	6,055	1.24	2.52	3.40
St. Mary's	1,360	2.57	4.29	4.07
E. W. McCready Memorial	5,953	1.34	1.47	4.05
Easton Emergency	16,614	0.93	1.13	3.90
Washington County	11,632	0.86	1.93	4.44
Peninsula General	15,474	1.29	1.39	3.82
Total (16 hospitals)	150,153	$1.30*	$1.92*	$3.78*

*Average for 16 hospitals in counties of Maryland.
**This hospital also received financial assistance from the County Commissioners of Allegany County in the form of capital expenditures and maintenance.

Apparently, the definition of these terms has not been standardized. For example, in ten hospitals a case was classified as "free" so long as the patient did not pay full ward rates. Partial payments in some cases were credited to the "general expense fund" and the patient carried as a "free" State case.

(b) There was little uniformity of standards for determining the financial status of applicants for free hospitalization.

In some hospitals the physicians' statement was the basis for classifying the patient. In others, the superintendent investigated each applicant, unless the financial status of the prospective patient was definitely known. In still others, the county commissioners, welfare or health departments were asked to make a decision.

(c) Local appropriations, presumably allocated for the care of the indigent, were utilized in a variety of ways.

In addition to State allocations, nearly every hospital received funds from local appropriating agencies, either directly or in the form of capital expenditures and maintenance. In some cases local funds were designated for the maintenance of free beds. In others, appropriations were placed in the "general fund" of the hospital. In only a few cities and counties did it appear necessary for hospitals to render an accounting of the manner in which the funds were expended, or to submit a list of free patients hospitalized.

[1]State of Maryland, Department of Public Welfare, Twentieth Biennial Report, 1939-40, Pages 47 and 51.

2. *State Appropriations to Certain Counties*

Although Garrett and Prince George's counties had no hospitals, the County Commissioners received in 1939-40 appropriations from the State of $6,000 and $8,000, respectively, for hospitalization of the medically indigent. The County Commissioners of Montgomery County, which possessed a hospital to which a State appropriation also was made, received a grant of $5,000 from the State for hospitalization of indigent patients.

The appropriations to these counties, as well as the number of hospital days for which payment was made[1], and the amount paid per free hospital day are as follows:

County	State Appropriation	Free Hospital Days Paid For	Rate Per Free Hospital Day
Garrett	$6,000	4,350	$1.38
Montgomery	5,000	4,671	1.07
Prince George's	8,000	3,929	2.04
Total	$19,000	12,950	$1.47

Summary

Contending that State appropriations were grossly inadequate and that the allocation of funds was more or less arbitrary, more than one superintendent expressed the opinion, that unless an adverse balance could be shown by him, the State, for the subsequent biennium would reduce the appropriation.

From the figures that have been presented it seems clear that neither the State nor local governments adhered to a uniform standard in the allocation of funds for the treatment of free cases.

Important Deficiencies

While the majority of hospitals were well constructed, equipped and staffed by competent medical and other personnel, the following important deficiencies were noted:

1. There were no hospitals in 8 counties.

2. In a number of instances inadequate buildings and equipment were seen.
3. All hospitals lacked adequate facilities for the care of (a) chronic disease, (b) psychotic patients awaiting removal to State institutions, and (c) units for isolation and treatment of communicable disease.

1. *Counties without Hospitals*

Of the eight counties previously listed in which there was no hospital, there were four in which the need appeared to be more urgent than in others, namely, Baltimore, Prince George's, Carroll and Garrett counties.

(a) *Baltimore County*

For many years, Baltimore, the county with the largest area and population, has been without a hospital, depending upon the institutions in Baltimore City and in Pennsylvania. The recent rapid increase in population in areas which were not readily accessible to the hospitals of Baltimore City, revived the movement to construct an institution in the county. A detailed survey of the situation was made by the Committee on Medical Care, and a special report presented to the County Commissioners of Baltimore County. From this report it was evident that Baltimore County can not long continue to rely upon the charitable resources of the hospitals of Baltimore City.

From the data assembled, it is perfectly clear, in the opinion of the Executive Committee, that Baltimore County either will have to make provisions within its own borders for hospitalization of its citizens, or adequately compensate the hospitals of Baltimore City.

(b) *Prince George's County*

A rapidly increasing population, particularly in areas adjoining the District of Columbia, and constant difficulty in securing admission to overcrowded institutions in the District, stimulated the formation of organized groups of citizens intent upon the construction of a hospital in Prince George's County, with the aid of the Federal Government*. While protracted negotiations were proceeding, a 50 bed hospital was built at Riverdale by private interests, which may assist in relieving conditions somewhat, but by no means will solve the problem.

(c) *Carroll County*

Conditions in Carroll County were comparable with those in Baltimore County. Possessing no hospital, it was necessary to transport patients either to the City of Baltimore or to an adjoining county in Pennsylvania. At the time of the survey, there did not appear to be the slightest interest in the construction of a local hospital, either among the medical profession or citizens. Executives in the county welfare department expressed the need for the establishment of medical and surgical clinics.

(d) *Garrett County*

Oakland, the county seat of Garrett County, and populated areas in the vicinity were at least 75 miles from the nearest hospital in Maryland. In winter, travel is often difficult—if not impossible, and serious delays in transporting patients to hospitals were reported. Intense interest in the construction of a new hospital was manifested especially among the physicians in Oakland. For many years, and continuing until about 1933, a privately owned hospital of about 25 beds was operated successfully in that town.

2. *Inadequate Buildings and Equipment*

Inadequate buildings and equipment existed in Harford Memorial and in the Union Hospital of Cecil County. These hospitals not only were overcrowded, but were serious fire hazards. In fact, fire hazard is absent in only a few of the smaller institutions.

3. *General Deficiencies*

(a) *Lack of Facilities for the Care of the Chronically Ill*

The general lack of provisions for the care of patients suffering from chronic disease was keenly felt by all hospitals. It was emphasized that because beds were occupied by the chronically ill, admission of acute cases sometimes had to be delayed or even refused. One superintendent stated that one patient had occupied a bed in his hospital for over 15 years, and repeated efforts to have him removed had failed.

It was estimated that hospital care for a chronic case costs at least $1,200 per year. As soon as a new State appropriation was received, it was asserted, it was necessary immediately to discount that amount or at least a portion thereof, for each chronic case occupying a bed. It was also stated that, as a rule, such a patient did not need the relatively expensive facilities of a general hospital.

(b) *Inadequate Facilities for Care of Psychotic Patients Awaiting Removal to State Institutions*

Hospital superintendents asserted that psychotic patients usually were unmanageable, disturbed other patients and required the services of at least one day and one night nurse. Psychiatrists, on the other hand, maintained that with proper management, mentally disturbed persons need not annoy other patients. At present, most psychotic patients who can not be controlled in the home are confined to the county jail until a bed can be found in a State institution. While in jail, these patients are under the care of individuals who are absolutely without training or experience in dealing with the sick.

*In Mongtomery County which also adjoins the District of Columbia, and which has one 40 bed hospital, groups of citizens organized in 1941 to urge the construction of another hospital.

(c) *Lack of Isolation Units for Communicable Disease*

As a result of education of the public by the medical profession and health departments, together with the increased efficiency of control methods, the fear of communicable disease, so intense for centuries, has been diminished. Beliefs that all infections are airborn, and that epidemics could be controlled only by confining the sick to "pest houses" miles from other dwellings, have been radically changed. Most communities now are aware that the placement of cases of communicable disease on the "poor farm" is an unwarranted and often cruel solution of the problem, and that a patient may now be treated, with safety to others, in a communicable disease unit of a general hospital—although the institution may be located in the center of a city.

If educational efforts are intensified, *every* county in Maryland will discontinue the use of the "pest house", and citizens will insist that each county establish a communicable disease unit in connection with the local hospital, even if minor changes in construction may be necessary.

A unit of from four to six beds probably would be sufficient to meet the ordinary requirements even in the larger hospitals. It is believed that these units could be maintained more economically than two or three large communicable disease hospitals located in various parts of the State, which appears to be the only alternative.

When these units have been established, the spread of communicable disease may be controlled more promptly and hospitals in the counties of Maryland will then fulfill more completely their responsibilities to the communities they are striving to serve.

Residents of Counties Hospitalized Elsewhere

With eight counties possessing no hospitals, and others having institutions of insufficient capacity, inadequate equipment or personnel, many county residents were hospitalized each year in the City of Baltimore, the District of Columbia, Pennsylvania, West Virginia and Delaware.

County Patients Admitted to Hospitals in the City of Baltimore

In 1940 a total of 16,582 county residents were admitted to hospitals in the City of Baltimore in which are located several large medical centers and a number of the most distinguished physicians and surgeons in the field of medicine. It should be added, however, that patients also were sent to Baltimore occasionally because it was known that the State of Maryland made appropriations each year for the care of free patients in all general hospitals in that City as well as in the counties. It apparently was not known, or not fully appreciated, as will be pointed out later, that these contributions were not sufficient to pay for hospitalization for free cases from the City of Baltimore, much less for those from the counties.

In Table 31, page 38, the number of hospital admissions of county residents in the City of Baltimore in 1940 has been shown, as well as the total patient days and the admissions per 1,000 population in the county of residence. A total of 16,582 county patients were admitted for 225,340 patient-days, or an average of 13.6 days per patient, with 17.3 admissions per 1,000 in the total counties. The number of admissions per 1,000 in the county of residence was highest in Howard County (58.2), Baltimore County (50.6), and Carroll County (34.9). None of these counties had general hospitals. In other counties the proportion of admissions per 1,000 population decreased, in general, with the distance from Baltimore City, as is shown graphically on Chart III, page 37.

1. *Pay Status of County Patients*

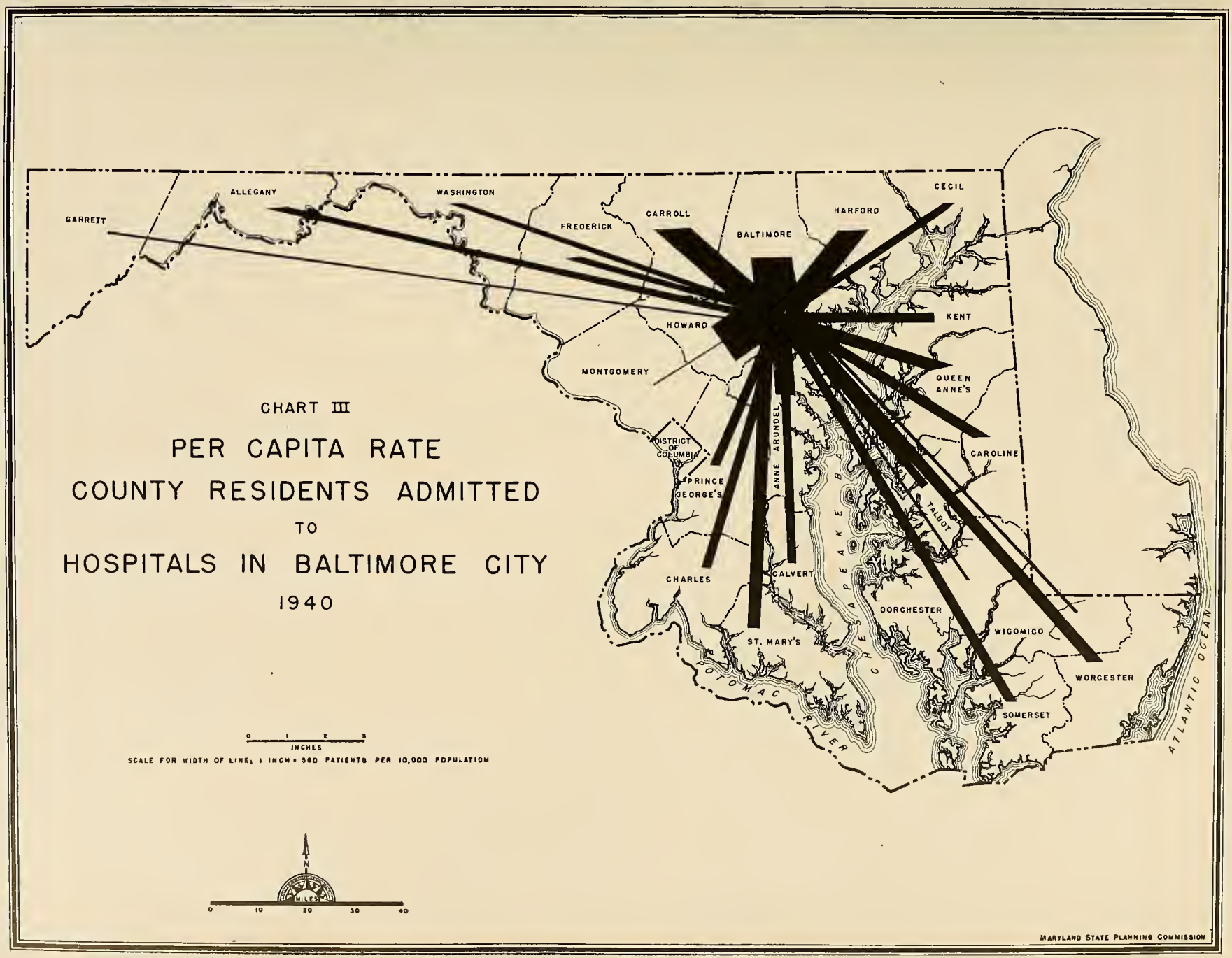
In Table 32, page 38, the number of county patients admitted to hospitals in Baltimore City in 1940 are presented with the number per 1,000 population in the county of residence and the pay status—pay, part-pay, and free. Of the 16,582 admissions, 7,306, or 44.1 percent, were pay patients; 4,194 or 25.3 percent, were part-pay; and 5,082, or 30.6 percent, were classified as free patients.

In Table 33, page 39, the total hospital days and the number of pay, part-pay and free patient days of county residents admitted to hospitals in the City of Baltimore in 1940 are tabulated. Of the 225,340 hospital days, 83,018, or 36.8 percent, were pay patients; 54,381, or 24.1 percent, were part-pay; 76,474, or 33.9 percent were free patients; and for 11,467 hospital days, or 5.2 percent, the pay status of the patient was not known.

The total pay patients, the number of free patients from Baltimore City and the counties admitted to 15 hospitals in that City *in the fiscal year 1939-40*, as reported to the State Department of Public Welfare, together with the number of hospital days of city and county patients have been tabulated as follows:

Fifteen Hospitals in Baltimore City	Pay Patients	Free Patients			Total
		City	County	Total	
Number of Patients	46,262	23,437	7,740	31,177	77,439
Percent	59.7	— 75.2	— 24.8	40.3 100.0	100.0

Of the 77,439 patients, 46,262, or 59.7 percent were pay, and 31,177, or 40.3 percent were free patients. Of the 31,177


GARRETT
ALLEGANY
WASHINGTON
FREDERICK
CARROLL
BALTIMORE
HARFORD
CECIL
KENT
QUEEN ANNE'S
CAROLINE
TALBOT
DORCHESTER
WICOMICO
WORCESTER
SOMERSET
HOWARD
MONTGOMERY
DISTRICT OF COLUMBIA
PRINCE GEORGE'S
ANNE ARUNDEL
CALVERT
CHARLES
ST. MARY'S
CHESAPEAKE BAY
POTOMAC RIVER
ATLANTIC OCEAN
CHART III
PER CAPITA RATE
COUNTY RESIDENTS ADMITTED
TO
HOSPITALS IN BALTIMORE CITY
1940
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INCHES
SCALE FOR WIDTH OF LINE, 1 INCH = 360 PATIENTS PER 10,000 POPULATION
N
0 10 20 30 40
MILES
MARYLAND STATE PLANNING COMMISSION

free patients, 23,437, or 75.2 percent, were residents of Baltimore City while 7,740, or 24.8 percent, were county residents.

It was also reported to the State Department of Public Welfare that 23,437 Baltimore patients were hospitalized for 321,507 days, or 13.7 days per patient, and 7,740 county residents remained a total of 134,120 days in these institutions, or an average of 17.3 days per patient. For all of the 31,177 free patients the number of days' hospitalization was 455,627, or 14.6 days per patient.

County Patients Hospitalized in the District of Columbia

Quite naturally, the hospitals of the District of Columbia were reluctant to admit patients from other political units in the absence of assurance that charges would be paid either by the patient or by a public or private agency in the city or county of residence. It has been found, however, that in the year 1940 the District of Columbia hospitalized 415 free patients for a total of 7,448 hospital days who were residents of Maryland, particularly the adjoining counties, Montgomery and Prince George's.

Data on the number of county residents admitted to the hospitals in the District of Columbia were obtained from the Health Security Administration, a private agency to which applicants for admission to District hospitals were referred for credit rating and, if necessary, for financing of hospital charges. This organization also was utilized by the Community Chest of the District of Columbia which included among its beneficiaries persons living in the suburban areas in Montgomery and Prince George's counties. It was stated that the purpose of the credit investigation was the determination of the extent to which the Community Chest was justified in assuming responsibility for hospital expenses. In addition to patients referred by hospitals to the Health Security Administration, it was said that other individuals, residents of the counties of Maryland, were hospitalized without reference to that organization, presumably because their credit rating was known to be satisfactory.

The data provided by the Health Security Administration, with the permission of the hospitals of the District, and by the Department of Health of the District of Columbia which administers Gallinger Hospital, have been summarized in the tables which follow.

TABLE 31

NUMBER OF ADMISSIONS OF COUNTY RESIDENTS TO HOSPITALS IN THE CITY OF BALTIMORE IN 1940, TOGETHER WITH THE TOTAL PATIENT-DAYS AND ADMISSIONS PER 1,000 POPULATION IN THE COUNTY OF RESIDENCE.

County of Residence	Total Patients Admitted	Total Patient Days	Admissions per 1,000 Population
Howard	1,000	13,299	58.2
Baltimore	7,886	95,658	50.6
Carroll	1,362	18,031	34.9
Harford	1,148	15,012	32.7
Anne Arundel	1,771	26,974	25.9
St. Mary's	210	2,955	14.4
Cecil	325	3,853	12.3
Calvert	126	2,628	12.0
Queen Anne's	153	2,977	10.6
Kent	140	2,345	10.4
Charles	141	2,808	8.0
Frederick	424	7,233	7.4
Prince George's	499	7,445	5.6
Somerset	117	2,535	5.6
Talbot	99	1,780	5.3
Caroline	92	1,426	5.2
Worcester	107	1,958	5.0
Dorchester	130	1,918	4.6
Wicomico	145	2,879	4.2
Washington	225	3,195	3.3
Garrett	68	1,407	3.1
Montgomery	190	3,717	2.3
Allegany	157	2,660	1.8
County not Specified	67	647	—
Total	16,582	225,340	17.3*

*Admissions per 1,000 population in the total counties of Maryland.

TABLE 32

COUNTY RESIDENTS ADMITTED TO HOSPITALS IN CITY OF BALTIMORE IN 1940. THE TOTAL NUMBER OF PATIENTS, THE NUMBER PER 1,000 POPULATION IN THE COUNTY OF RESIDENCE AND THE PAY STATUS.

County of Residence	Total Patients	Number per 1,000 Population	Pay Status of Patients		
			Pay	Part-Pay	Free
Howard	1,000	58.2	361	267	372
Baltimore	7,886	50.6	3,631	2,149	2,106
Carroll	1,362	34.9	605	307	450
Harford	1,148	32.7	458	368	322
Anne Arundel	1,771	25.9	755	418	598
St. Mary's	210	14.4	38	32	140
Cecil	325	12.3	115	107	103
Calvert	126	12.0	48	18	60
Queen Anne's	153	10.6	61	22	70
Kent	140	10.4	43	31	66
Charles	141	8.0	30	16	95
Frederick	424	7.4	181	102	141
Prince George's	499	5.6	244	130	125
Somerset	117	5.6	53	19	45
Talbot	99	5.3	58	13	28
Caroline	92	5.2	42	11	39
Worcester	107	5.0	49	15	43
Dorchester	130	4.6	54	39	37
Wicomico	145	4.2	71	18	56
Washington	225	3.3	145	31	49
Garrett	68	3.1	22	16	30
Montgomery	190	2.3	116	27	47
Allegany	157	1.8	96	18	43
County not Specified	67	—	30	20	17
Total	16,582	17.3*	7,306	4,194	5,082
Percent			44.1	25.3	30.6

*Admissions per 1,000 population in the total counties of Maryland.

In Table 34, page 40, the county residents hospitalized in nine hospitals in the District of Columbia in 1940 are shown, as well as the total patients by color and pay status. Of the 1,243 patients, 1,084, or 87.2 percent, were white, and 159, or 12.8 percent, were colored. A total of 290, or 23.3 percent, were pay; 538, or 43.3 percent, were part-pay; and 415, or 33.4 percent, were free patients. In Table 35, page 40, the distribution is given by county of residence and pay status. Of the 1,243 patients, 197, or 15.8 percent, were residents of Montgomery County; 999, or 80.4 percent, resided in Prince George's County; and 47, or 3.8 percent, were residents of other counties.

In Table 36, page 41, the days spent by residents of the counties of Maryland in twelve hospitals of the District of Columbia in 1940 are shown together with their pay status. Of a total of 17,226 hospital days, 2,203, or 12.8 percent, were pay; 7,575, or 44.0 percent, were part-pay; and 7,448, or 43.2 percent, were free hospital days. In Table 37, page 41, the hospital days for the same patients are shown by pay status and by county of residence. It will be noted that 3,138 hospital days, or 18.1 percent, were residents of Montgomery County; 13,195, or 76.6 percent, resided in Prince George's County; and 893, or 5.3 percent, were residents of other counties in Maryland.

TABLE 33

PATIENT-DAYS HOSPITALIZATION OF COUNTY RESIDENTS IN HOSPITALS IN THE CITY OF BALTIMORE IN 1940.

County	Total Hospital Days	Hospital Days			
		Pay Patients	Part-Pay Patients	Free Patients	Unknown Pay Status
Howard	13,299	4,205	2,452	5,473	1,169
Baltimore	95,658	38,318	25,836	25,442	6,062
Carroll	18,031	6,372	4,277	6,846	536
Harford	15,012	4,670	4,668	4,660	1,014
Anne Arundel	26,974	11,322	5,746	8,849	1,057
St. Mary's	2,955	438	362	1,796	359
Cecil	3,853	560	1,447	1,669	177
Calvert	2,628	666	309	1,628	25
Queen Anne's	2,977	754	344	1,805	74
Kent	2,345	476	309	1,530	30
Charles	2,808	272	246	2,256	34
Frederick	7,233	2,538	1,746	2,547	402
Prince George's	7,445	3,165	2,189	1,972	119
Somerset	2,535	692	240	1,603	—
Talbot	1,780	596	354	777	53
Caroline	1,426	641	174	611	—
Worcester	1,958	475	252	1,229	2
Dorchester	1,918	605	572	740	1
Wicomico	2,879	990	513	1,327	49
Washington	3,195	1,636	744	759	56
Garrett	1,407	314	327	757	9
Montgomery	3,717	1,736	633	1,180	168
Allegany	2,660	1,357	486	779	38
County not Specified	647	220	155	239	33
Total	225,340	83,018	54,381	76,474	11,467
Percent	—	36.8	24.1	33.9	5.2

In Table 38, page 41, a summary is presented of the number of patients, hospital days and the average stay of pay, part-pay and free patients in hospitals in the counties of Maryland for the fiscal year 1939-40, and for county residents hospitalized in Baltimore City and in the District of Columbia in 1940.

Of the total of 46,163 patients, 23,305, or 50.5 percent, were pay; while 4,732, or 10.3 percent, were part-pay; and 18,126, or 39.2 percent, were free patients. It also will be observed that there were no part-pay patients in the hospitals in the counties, as reported to the State Department of Welfare. If the percent of pay and part-pay patients are added, the total is 69.4 percent for county patients admitted to hospitals in the City of Baltimore, and for those hospitalized in the District of Columbia it was 66.6 percent.

Of the 46,163 patients, 28,338, or 61.4 percent, were admitted to 16 hospitals in the counties of Maryland; 16,582, or 35.9 percent, to 15 hospitals in Baltimore City; and 1,243, or 2.7 percent, to 9 hospitals in the District of Columbia.

County Residents Hospitalized in Other States

In the counties bordering Pennsylvania, West Virginia and Delaware, it was reported that it was not unusual for local residents to be hospitalized in adjoining states. In other counties, it was declared that residents from neighboring states not infrequently were admitted to hospitals in the counties of Maryland. Complete figures could not be obtained readily. It was our impression that the number of county residents hospitalized in other states probably approximated that of residents of adjoining States admitted to hospitals in the counties of Maryland.

Summary

Eighteen hospitals with a total of 1,331 beds, excluding bassinets, were located in 15 of the 23 counties. There were no hospitals in 8 counties. Six institutions had more than 100 beds, 3 had from 50 to 99 beds, and there were 9 with less than 50 beds.

Fifteen hospitals were operated by non-profit corporations, 1 by the State, 1 by Frederick County Commissioners, and 1 by the Sisters of Charity. In 15 hospitals the business of each was administered by a Board of Directors and a superintendent.

In 14 hospitals the superintendent was a graduate nurse, while in 3 of the largest a layman, experienced in hospital administration, served in that capacity.

Ladies auxiliaries were active in nearly every hospital.

As a rule, surgical, anesthesia and emergency services were well-equipped. Outpatient departments were almost entirely lacking, although 6 hospitals provided space for clinics conducted by the county health department to which certain types of patients were referred upon discharge from the hospital.

In general, obstetrical departments were adequately staffed and equipped.

Clinical laboratories of variable capacities were maintained in 14 hospitals. A combined clinical and public health laboratory had commenced to function in Charles, Calvert and St. Mary's counties.

X-ray services were found in all hospitals, 4 of which were in charge of full-time Roentgenologists.

Dietetic services were functioning in most hospitals, pharmacies in 3, and a department of physiotherapy in 1 hospital. Medical social services were lacking.

Medical record rooms varied widely in efficiency of maintenance.

Ambulance services were maintained in 2 hospitals. In other counties this service was operated by morticians, the State Police, local fire departments, county commissioners and associations of citizens. It is suggested that a State-wide agency be assigned the task of coordinating and, when necessary, supplementing existing ambulance services.

In the year 1939-40, 17 hospitals received a total of $241,833 of which $184,795 was allocated by the State and $57,038 by county and city governments. In addition, $19,000 was appropriated by the State for hospitalization of the indigent in 3 counties.

A total of 28,338 patients were admitted to 15 hospitals, of whom 15,709, or 55.4 percent, were classified as pay, and 12,629, or 44.6 percent, as free patients, according to reports received by the State Department of Welfare.

TABLE 34

COUNTY RESIDENTS HOSPITALIZED IN THE DISTRICT OF COLUMBIA IN 1940, THEIR COLOR AND PAY STATUS, BY HOSPITALS.

Hospital	Full Pay		Part-Pay		Free		Total Patients		
	W	C	W	C	W	C	W	C	T
Children's	35	4	100	12	21	14	156	30	186
Columbia	30	1	81	7	9	—	120	8	128
Emergency	21	1	16	2	14	—	51	3	54
Episcopal	14	5	28	4	15	6	57	15	72
Gallinger	—	—	—	—	194	48	194	48	242
Garfield	28	6	33	16	6	5	67	27	94
Georgetown	9	—	20	10	14	6	43	16	59
George Washington	12	—	21	—	6	—	39	—	39
Providence	104	6	186	2	49	4	339	12	351
Others	14	—	—	—	4	—	18	—	18
Totals	267	23	485	53	332	83	1,084	159	1,243
Percent	23.3		43.3		33.4		100.0		

TABLE 35

COUNTY RESIDENTS, BOTH WHITE AND COLORED, HOSPITALIZED IN THE DISTRICT OF COLUMBIA IN 1940, THEIR COUNTY OF RESIDENCE AND PAY STATUS

County of Residence	Pay	Part-Pay	Free	Total Patients	Percent of Total
Montgomery	55	90	52	197	15.8
Prince George's	224	442	333	999	80.4
Other Counties	11	6	30	47	3.8
Total	290	538	415	1,243	100.0

It appears that 16 hospitals receive an average of $1.30 from the State, and $1.92 from State *and* local government sources for each free hospital day, the average cost of which was estimated as $3.78. It would appear, therefore, that State and local appropriations should be approximately doubled in order to compensate hospitals for the care of the indigent.

Differences in administrative practice among hospitals included variations in (a) interpretation of terms such as "free case" and "free hospital day", (b) standards for determining the financial status of applicants for free hospitalization, and (c) the utilization of local funds presumably intended for payment for free cases.

On account of the above variations, many of the figures presented in tables in this chapter can not be considered comparable, one hospital with the other.

TABLE 36

RESIDENTS OF THE COUNTIES OF MARYLAND HOSPITALIZED IN DISTRICT OF COLUMBIA HOSPITALS IN 1940, INDICATING THE TOTAL HOSPITAL DAYS AND PAY STATUS, BY HOSPITALS

Hospital	Pay	Part-Pay	Free	Total
Children's	314	1,540	1,215	3,069
Columbia	297	994	164	1,455
Emergency	190	280	365	835
Episcopal	99	194	194	487
Garfield	481	1,215	606	2,302
Gallinger	—	—	2,954	2,954
Georgetown	16	395	448	859
George Washington	202	345	209	756
Providence	535	2,452	1,241	4,228
Florence Crittenton	44	—	48	92
Casualty	25	—	4	29
Prince George's Health Center	—	160	—	160
Total	2,203	7,575	7,448	17,226
Percent	12.8	44.0	43.2	100

TABLE 37

HOSPITAL DAYS PROVIDED COUNTY RESIDENTS IN THE DISTRICT OF COLUMBIA IN 1940, INDICATING PAY STATUS AND COUNTY OF RESIDENCE, TOGETHER WITH THE PERCENT OF TOTAL HOSPITAL DAYS

County of Residence	Pay	Part-Pay	Free	Total	Percent of Total
Montgomery	518	1,349	1,271	3,138	18.1
Prince George's	1,619	6,173	5,403	13,195	76.6
Other Counties	66	53	774	893	5.3
Total	2,203	7,575	7,448	17,226	100.0

There did not appear to be standard stipulations for the expenditure of the $19,000 appropriated annually for hospitalization of the indigent in 3 counties.

Neither State nor local governments adhered to a uniform standard in the allocation of funds for the hospitalization of free cases.

Other important deficiencies included (a) 8 counties were without hospitals, (b) inadequate buildings and equipment were found in at least 2 institutions, and (c) there was a State-wide lack of facilities for care of (i) chronic disease, (ii) psychotic patients awaiting removal to State institutions, and (iii) patients with communicable disease. It is suggested that facilities be provided in hospitals for care of psychotic patients and for the isolation and treatment of cases of communicable disease.

In 1940, a total of 16,582 county residents was admitted to hospitals in Baltimore City for 225,340 hospital days, or an average of 13.6 days per patient. Of the 16,582 admissions, 7,306, or 44.1 percent were pay; 4,194, or 25.3 percent were part-pay; and 5,082, or 30.6 percent were free patients.

In 1940, a total of 1,243 county patients was hospitalized in 9 hospitals in the District of Columbia, of whom 290,

TABLE 38

THE NUMBER OF PATIENTS, TOTAL PATIENT DAYS AND AVERAGE STAY IN HOSPITAL OF PAY, PART-PAY AND FREE PATIENTS IN INSTITUTIONS IN THE COUNTIES OF MARYLAND IN 1939-40, AND FOR COUNTY RESIDENTS HOSPITALIZED IN THE CITY OF BALTIMORE AND IN THE DISTRICT OF COLUMBIA IN 1940

Financial Status of Patients		County Residents Hospitalized in			Total
		Counties of Maryland	City of Baltimore	District of Columbia	
Pay		55.4%	44.0%	23.3%	50.5%
	Patients	15,709	7,306	290	23,305
	Hospital Days	142,538	82,018	2,203	226,759
	Average Stay	9.1	11.2	7.6	9.7
Part-Pay		—	25.4%	43.3%	10.3%
	Patients	—	4,194	538	4,732
	Hospital Days	—	53,381	7,575	60,956
	Average Stay	—	12.7	14.1	12.9
Free		44.6%	30.6%	33.4%	39.2%
	Patients	12,629	5,082	415	18,126
	Hospital Days	150,153	76,474	7,448	234,075
	Average Stay	11.9	15.0	17.9	12.9
Total		100.0%	100.0%	100.0%	100.0%
	Patients	28,338	16,582	1,243	46,163
	Hospital Days	292,511	225,340	17,226	535,077
	Average Stay	10.3	13.6	13.8	11.6

or 23.3 percent were pay; 538, or 43.3 percent were part-pay; and 415, or 33.4 percent were free patients. Of the 1,243 admissions, 197, or 15.8 percent were residents of Montgomery County; 999, or 80.4 percent, resided in Prince George's County; and 47, or 3.8 percent, were residents of other counties.

Of the 46,163 county residents hospitalized in one year, 28,338, or 61.4 percent, were admitted to 16 hospitals in the counties of Maryland; 16,582, or 35.9 percent, to 15 hospitals in Baltimore City; and 1,243, or 2.7 percent, to 9 hospitals in the District of Columbia. Of the 46,163 patients, 23,305, or 50.5 percent, were pay; 4,732, or 10.3 percent were part-pay; and 18,126, or 39.2 percent, were free patients. The average stay in hospital was 11.6 days per patient; 9.7 days for pay, 12.9 for part-pay, and 12.9 for free cases.

Chapter VII

HEALTH DEPARTMENT SERVICES

Introduction

In 1938 a comprehensive appraisal of the public health facilities of the State and counties of Maryland was made by Dr. John F. Kendrick and Dr. W. A. McIntosh of the staff of the International Division of the Rockefeller Foundation. A report of the study, "Public Health Administration in Maryland", was published in 1939 by the Maryland State Planning Commission. Since the data assembled therein were of such recent origin, the Committee on Medical Care decided to devote its attention chiefly to those phases of activity of the State and county health departments directly related to medical care.

Full-Time County Health Service

Maryland has the distinction of having been the first State in the United States to organize county-wide health service with full-time trained health personnel in each county.

Full-time service throughout the counties was started in 1914 by the division of the State, outside of Baltimore City, into ten sanitary districts, each consisting of two or three counties under the direction of a full-time deputy State health officer. More intensive service in individual counties was started by Allegany County in 1922. The other counties followed one by one, and at the close of 1934 each of the 23 counties was on a full-time basis. The headquarters of each unit is at the county seat.

The personnel of each county health department in 1940 included the county health officer, an assistant health officer in certain of the larger counties, two or more public health nurses, a sanitarian, other technical personnel including dentists and medical social workers, and one or more clerks. A tabulation of the personnel will be found in Table 39, page 44, which also includes the full-time personnel: population ratios. It will be seen that the latter varied between 1:2,244 in Kent and 1:13,018 in Carroll County. In contrast with the distribution of physicians, nurses, dentists, and hospital beds, the public health personnel was, in general, higher in the counties in the *lower* economic levels.

The maintenance of county health departments is financed jointly by the State Department of Health and city and county governments. The personnel is appointed on a merit basis, regardless of whether the salaries are paid with State or local funds or both.

The Program of County Health Departments

In 1940 the county health departments conducted a generalized public health program, under the direction of the county health officer, of which the principal activities were: (1) communicable disease control including immunization, venereal disease and tuberculosis clinics; (2) public health nursing; (3) clinics for expectant mothers, child health conferences and health services for school children; (4) services for crippled children; (5) mental hygiene clinics; (6) bacteriological laboratory service in eight counties; (7) dental clinics; (8) public health education and information services; (9) sanitation including milk, water and food control, as well as sewerage disposal and other types of community hygiene.

1. *Communicable Disease Control in 1940*

(a) *General*

There were 13,837 cases of notifiable diseases reported to the State Department of Health from the counties of Maryland in 1940, and nearly 7,900 home visits were made by the health officers and public health nurses to discover sources of infection or to take measures to prevent the spread of disease[1]. Over 17,000 young children were immunized against diphtheria; 5,500 persons were protected against typhoid fever and over 6,000 were vaccinated against smallpox. These protective measures were carried out with the cooperation of county medical societies.

(b) *Tuberculosis*

Over 5,700 persons were examined at the monthly chest clinics held in cooperation with the Maryland Tuberculosis Association, 581 were admitted to sanatoria and 12,275 home visits were made to persons who were suffering from tuberculosis or who had been in contact with that infection.

(c) *Venereal Diseases*

Venereal disease clinics were held in every section of the State with over 9,000 persons admitted for diagnosis or treatment. Over 83,000 treatments were given and over 8,800 follow-up visits were made to the homes of patients.

2. *Public Health Nursing*

There has been a constant increase in the number of public health nurses. In 1922, there were 22 nurses, and at the close of 1940 there was a total of 110. In addition to

[1]Annual Report of the State Board of Health of Maryland, 1940.

the nurses on duty in the counties, the public health nursing staff of the State Department of Health included a nurse instructor and assistant instructor, nurse consultant in maternal and child hygiene, three nurse midwives, and two orthopedic nurses connected with the services for crippled children. With the exception of those assigned to special services, the county nurses carried on a generalized program under the direction of the county health officer.

3. *Pre-natal Clinics, Child Health Conferences, and Health Services for School Children*

Nearly 2,500 expectant mothers were enrolled at the pre-natal clinics; 13,568 young children were examined at the child health conferences; and more than 46,000 home visits were made by the public health nurses in connection with these services.

Health supervision of the older children included the physical examination of over 41,500 school children, and 131,115 inspections were made in connection with the control of communicable disease in the schools. Dental clinics were also a part of the school health services, as has been indicated elsewhere in this report, and over 12,000 children had some type of dental attention.

4. *Services for Crippled Children*

Over 2,300 physically handicapped children had the benefit of supervision and treatment in the Services for Crippled Children. A total of 252 children was hospitalized, 12,446 physio-therapy treatments were given, and 5,764 home nursing visits were made to the children for followup care.

5. *Mental Hygiene Clinics*

Over 800 persons—670 of whom were under 21—were examined at the mental hygiene clinics conducted under the joint auspices of the Bureau of Child Hygiene of the State Department of Health, the State Commissioner of Mental Hygiene, the State Mental Hygiene Society, the county departments of health and the school authorities. The examinations were given by psychiatrists connected with the State, Baltimore City or local hospitals or institutions. A total of 101 clinics was held in 21 counties.

6. *Bacteriological Laboratories*

The Bureau of Bacteriology of the State Department of Health, with a central laboratory in Baltimore and eight branch laboratories throughout the State, has developed an extensive laboratory service. The total examinations increased from 15,600 in 1920 to 82,909 in 1930, and 278,919 in 1940. The prodigious growth of this service is obvious. A high proportion of the increase during the past several years has been attributed to syphilis serology.

The number and type of personnel engaged in laboratoty work in the central laboratory in Baltimore and in each of the branch laboratories are as follows:

	Bacteriologists and Assistant Bacteriologists	Laboratory Assistants and Helpers	Clerks and Stenographers
Central Laboratory	13	14	7
Branch Laboratories:			
Cumberland	2	1	—
Hagerstown	1	1	1
Hurlock	2	1	1
Frederick	1	1	1
Rockville	1	2	—
Salisbury	1	1	1
Elkton	1	1	1
Annapolis	1	1	1
Total	23	23	13

TABLE 39

ORGANIZATION OF THE COUNTY HEALTH DEPARTMENTS IN 1940, INDICATING THE NUMBER OF FULL-TIME COUNTY HEALTH OFFICERS, PUBLIC HEALTH NURSES, SANITARY OFFICERS AND DENTISTS, TOGETHER WITH THE PERSONNEL: POPULATION RATIO.

County	Public Health Officers	Public Health Nurses	Sanitary Inspectors	Dentists	Total*	Personnel: Population Ratio
Kent	1	4	1	—	6	1:2,244
Queen Anne's	1	4	1	—	6	1:2,413
Calvert	1	2	1	—	4	1:2,621
Anne Arundel	2	19**	2	—	23	1:2,973
Caroline	1	3	1	—	5	1:3,510
Charles	1	3	1	—	5	1:3,522
Worcester	1	4	1	—	6	1:3,541
St. Mary's	1	2	1	—	4	1:3,656
Garrett	1	4	1	—	6	1:3,663
Talbot	1	3	1	—	5	1:3,757
Somerset	1	3	1	—	5	1:4,193
Wicomico	1	6	1	—	8	1:4,316
Cecil	1	3	1	—	5	1:5,281
Allegany	2	10	4	—	16	1:5,425
Dorchester	1	3	1	—	5	1:5,601
Howard	1	2	—	—	3	1:5,725
Montgomery	1	8	3	—	12	1:6,993
Washington	1	5	2	1	9	1:7,649
Frederick	1	4	2	—	7	1:8,187
Harford	1	2	1	—	4	1:8,765
Prince George's	2	5	2	—	9	1:9,943
Baltimore	2	9	1	—	12	1:12,985
Carroll	1	2	—	—	3	1:13,018
Total Counties	27	110	30	1	168	1:5,727

*In addition to those listed, other technical personnel and one or more clerks were employed in each county.

**In this county, there was an intensive development of maternal and child hygiene services, necessitating an increase in the staff.

Maintenance Costs

The budget for the State Department of Health for the year 1940-41 has been summarized in Table 40, page 45. The total for the year was $1,978,221, of which $782,669

were the estimated expenditures for the Health Department of Baltimore City; $661,587 were allocated for administrative costs, and $533,965 for the county health departments. Administrative costs included the maintenance of the many services in the central office of the State Department of Health in Baltimore, all of which benefited the counties directly, but the total could not be equally distributed among them.

The source of funds for the maintenance of county health departments included $212,259 from State and/or Federal sources, $196,783 from city and county governments, and $124,923 from other agencies.

In Table 41, page 46, the budgets of the county health departments are shown for the year 1940-41, together with the expenditures per capita, the local appropriations and the percentages of the budgets appropriated locally. The counties have been arranged in order of the per capita expenditures.

Budgets ranged from $74,520 in Anne Arundel County, in which an intensive maternal and child health program was being developed, to $9,572 in Carroll County. For the total counties the average budget was $23,216. The per capita costs varied from $1.51 in Queen Anne's to $0.25 in Carroll County, with an average expenditure of $0.58 per person.

Since there was comparatively little variation in the number of employees of county health departments, it is not surprising to find that the cost per capita was larger in the counties with relatively small populations.

The local appropriations, totalling $196,783, varied from $34,544 in Allegany to $1,486 in St. Mary's, with an average of $8,556 per county. The proportion of the budgets contributed locally extended from 70.0 percent in Allegany to 11.3 percent in St. Mary's County, with a mean of 35.5 percent. It will be noted that, as a rule, the highest local appropriations were made by the largest counties and by those in the higher economic levels.

Interviews with County Health Officers

Each county health officer was interviewed at length, and each county health department was inspected, particular attention being given to those facilities which provided for examination and treatment of patients.

The typical county health officer, in addition to a degree in medicine, possessed a degree or certificate in public health. The majority had been serving in their county for at least ten years.

Increase Reported in Requests for Medical Care

Each county health officer reported that during the past four or five years it had become necessary to assume, in addition to his usual activities, an ever increasing responsibility in arranging for medical care for the indigent and the medically indigent.

The majority of health officers agreed that very few patients who were able to visit the physician's office ever went untreated, and that many physicians devoted a great deal of time and effort during office hours to care of the indigent. Difficulties in securing medical care, they believed, were confined largely to those requesting home visits, particularly the chronically ill, and patients requiring a diagnostic study.

Health officers expressed the belief that those unable to secure medical attention might be divided into two general classes, (a) recipients of relief, particularly residents of counties in which arrangements for payment of physicians had not been completed, and (b) those indebted to physicians who habitually made no serious effort to discharge their obligations.

The indigent or medically indigent individual, failing to obtain continued services from the family physician, applied for aid either to another practitioner, to the county health department, the local hospital, the county welfare department, or the county commissioners, usually in this sequence.

In procuring medical care for such individuals, county health officers generally proceeded as follows:

After it had been determined that the patient actually needed medical attention and a tentative diagnosis was made, an attempt was made to ascertain the patient's financial status. This sometimes involved a telephone call

TABLE 40

BUDGET OF STATE DEPARTMENT OF HEALTH IN 1940-41 SHOWING TOTAL EXPENDITURES FOR THE COUNTIES OF MARYLAND, BALTIMORE CITY AND FOR ADMINISTRATIVE PURPOSES

	Source of Funds			
	Total	State &/or Federal	Local	Other Agencies
Total Counties	$ 533,965	$ 212,259	$ 196,783	$ 124,923
Baltimore City	782,669	27,059	755,610	—
Total Counties *and* Baltimore City	$1,316,634	$ 239,318	$ 952,393	$ 124,923
Administrative Costs	661,587	586,906	5,730	68,951
Total	$1,978,221	$ 826,224	$ 958,123	$ 193,874
Percent	100.0%	41.8%	48.4%	9.8%

to the county welfare department. If the patient were indigent and the condition a relatively simple one, the county health officer might risk the accusation of engaging in the private practice of medicine and give such treatment or advice as was indicated. As a rule, however, the health officer either attempted to persuade the doctor named as the family physician to accept responsibility for the case, or called another physician who was known usually to be willing to assist those in need. Even the latter occasionally tires of receiving constant appeals, or, after a few such calls, the county health officer hesitates to impose further on good nature. If it seemed certain that the applicant was a hospital case, the local hospital was asked to admit the patient. If the request was granted, the hospital would then assume responsibility for procuring a physician. It was not unusual for the health officer to ask that the patient be admitted to a local hospital if the individual lived more than a few miles from the nearest physician's office. This would enable the patient to receive medical attention, and make it unnecessary to ask a physician to drive a number of miles each day to treat the case.

TABLE 41

THE BUDGETS OF THE COUNTY HEALTH DEPARTMENTS FOR THE YEAR 1940-41, INDICATING THE EXPENDITURES PER CAPITA, THE TOTAL LOCAL APPROPRIATIONS, AND THE PERCENTAGE OF THE TOTAL BUDGET APPROPRIATED LOCALLY, IN ORDER OF THE PER CAPITA EXPENDITURES.

County	Total Budget	Expenditures per Capita	Local Appropriations		
			Rank	Percent of Total Budget	Total
Queen Anne's	$ 21,868	$1.51	21	13.0	$ 2,836
Kent	17,716	1.32	13	28.9	5,114
Calvert	11,569	1.10	16	24.6	2,847
Anne Arundel	74,520	1.09	22	11.6	8,650
Somerset	17,873	.95	18	22.6	4,047
Charles	16,642	.94	20	14.0	2,328
St. Mary's	13,081	.89	23	11.3	1,486
Worcester	18,506	.87	11	30.1	5,577
Caroline	13,607	.78	14	27.1	3,681
Garrett	16,096	.73	12	29.5	4,743
Wicomico	24,637	.71	17	23.5	5,789
Talbot	12,803	.68	15	25.2	3,223
Howard	10,178	.59	6	47.8	4,869
Dorchester	15,931	.57	19	16.1	2,574
Allegany	49,312	.57	1	70.0	34,544
Cecil	12,739	.48	10	37.5	4,781
Montgomery	40,633	.48	3	58.9	23,919
Washington	29,804	.43	4	51.5	15,360
Frederick	21,903	.38	8	38.9	8,512
Harford	13,398	.38	7	43.2	5,791
Prince George's	28,983	.32	5	51.1	14,799
Baltimore	42,557	.27	2	65.0	27,657
Carroll	9,572	.25	9	38.2	3,654
Total Counties	$533,965*	$0.58	—	35.5	$196,783*

*The average budget was $23,216, with a mean appropriation of $8,556 per county.

Analysis of Requests for Medical Care Received by County Health Departments

It has been noted that, in addition to their usual functions, county health officers almost unanimously declared that they had been obliged to assume an ever increasing responsibility for arranging for medical care of the indigent or for those who claimed to be in that status. Activities of this kind were not regarded as a part of their official duties and reports of this work, therefore, were not submitted either to county commissioners or to the State Department of Health. To obtain estimates of the volume and character of these unmet needs, county health officers were requested to submit each month to the Committee on Medical Care the following information:

1. The age, sex, race and economic status of each individual applying for medical care.
2. The name of the person or agency from whom the request was received.
3. The reason for applying to the county health department.
4. The disposition of the case.

Eight counties sent the Committee information regularly in sufficient detail to warrant its use. These were Anne Arundel, Baltimore, Cecil, Charles, Harford, Howard, Talbot, Worcester counties. The period covered by each varied from four to eight months, with an average of seven months. In all cases the late winter and spring of 1940 were included.

In Table 42, page 47, the reports received from these eight county health departments are tabulated, together with estimates of the annual number of requests and of the rates per 1,000 population. The latter ranged from 2 in Anne Arundel, Harford and Worcester Counties to 10 per 1,000 in Cecil County. While considerable variation from county to county was expected, the extremes noted are believed to be the result of incomplete reporting.

Characteristics of Applicants

Persons applying to county health departments for medical care exhibited the following characteristics.

1. *Sex*

In five of the eight counties, males constituted less than 50 percent of the applicants. In three counties the proportion was less than 35 percent. It has long been established that women seek medical attention more frequently than men.

2. *Race*

The frequency of Negro applications varied considerably from county to county. When each percentage was com-

pared with that of the Negroes in the total county population, it was apparent in all counties that the proportions in this sample were higher than the percentage of Negroes in the total population.

3. *Age*

In all counties except Worcester, which reported only 21 applications, the percentage of applicants under 15 years of age was greater than the percentage of persons in this age group in the total population of their respective counties. The percentage of applicants over 45 was lower than the corresponding percentage for the total population. These findings are, in general, in agreement with established figures on the general morbidity in relation to age.

4. *Economic Status*

Information on the economic or occupational status of applicants or their parents was not as complete as was expected. However, taking into account those cases in which this information was recorded, it is clear that those "on relief" were in the minority, ranging from zero to 38 percent. Conversely, those not "on relief", comprised from 62 to 100 percent of the total. It is clear, therefore, that a high proportion of applicants for medical care were *not* recipients of relief and presumably self-supporting.

Origin of Requests

The majority of applications were made by the patients, their relatives or neighbors. The cases referred by the county welfare departments did not exceed 50 percent of the total in any of the counties, the majority of appeals were made directly to the county health departments. A small number of persons were referred to the Health Department by physicians.

The majority of applicants claimed that they had a family physician. Among those who asserted that an appeal for medical care had been made to other persons or agencies before coming to the Health Department, about 70 percent stated that a physician previously had been called upon.

TABLE 42

REQUESTS FOR MEDICAL CARE RECEIVED IN EIGHT COUNTY HEALTH DEPARTMENTS IN MARYLAND IN THE LATE WINTER AND SPRING MONTHS OF 1940

	County Health Departments							
	Anne Arundel	Baltimore	Cecil	Charles	Harford	Howard	Talbot	Worcester
Period Covered, Months	8	8	8	5	8	7	4	7
Total Requests Received	98	303	205	52	52	55	27	21
Total Estimated Requests per Year	131	404	273	143	77	94	81	36
Total Estimated Requests per Year, per 1,000 Population	2	3	10	7	2	6	4	2
Characteristics of Applicants								
(1) Sex—Percent Males	34	33	34	42	55	45	50	53
(2) Color—Percent White	41	78	78	30	81	75	31	63
(3) Age-(Percent) 0-14 years	48	38	34	45	43	37	31	13
15-44 years	41	43	54	45	33	32	40	52
45 years and over	11	20	11	10	24	31	29	35
(4) Economic Status Total "on relief"	5	41	14	6	11	13	1	0
Total not "on relief"	49	242	116	46	30	21	5	7
Unknown status	44	20	75	0	17	21	21	14
Applicants of Known Status Percent "on relief"	9	14	11	11	27	38	17	0
Not "on relief"	91	85	89	89	73	62	23	100
Requests Made By: (percent) Patient or Relative	29	62	83	74	65	31	83	83
Welfare Department	41	22	9	8	15	45	11	17
Physician	25	10	6	13	15	20	0	0
Other Agency	6	1	2	5	4	4	6	0
Applicants Claiming a Family Physician (Percent)	84	67	52	92	72	83	18	43
Applicants Claiming Request First Made to Family Physician (Percent)	64	50	68	67	0	93	0	92
Disposition: (Percent) Treated by Health Department	13	15	1	52	12	11	89	48
Treated by Private Physician at Request of Health Department	20	9	11	25	5	2	0	19
Hospitalized	67	76	88	23	83	87	11	33

Disposition of Requests

About 60 percent of those who applied to the Health Department were subsequently hospitalized. This might be interpreted as indicating that many of the applicants were acutely ill. However, there were other deciding factors. For example, in some cases home conditions were so insanitary that there was little hope of successful treatment there; or bedside nursing, even of the most elementary type, was not available; and distance from the nearest doctor's office was an important consideration in some instances.

About 30 percent of individuals were treated by the staff of the county health department, although the type of service rendered was not an official responsibility of that agency. Approximately 10 percent were referred to physicians, usually friends of the county health officer or public health nurses, because "no means, other than appeal to one's friends, has yet been provided for the treatment of 'charity' patients living in the counties of Maryland".

Data Inadequate for Accurate Estimate of Number of Medically Indigent

From these data it was expected that an estimate of the number of medically indigent in the counties of Maryland could have been made, but the information at hand does not appear to be sufficiently complete for this purpose. The number of requests received, however, served to confirm reports of health officers and others that persons in significant numbers were daily seeking medical care in or through the county health department.

Health Departments Prevent Unnecessary Hospitalization

The county health officer not only secured the hospitalization of patients but also assisted in reducing the number of hospital admissions. For example, at the request of the superintendent, the health officer or one of his nurses visited the homes of individuals who are without a physician and whose families, neighbors or friends urgently requested hospitalization. In a high proportion of such cases it was found that the patient required only simple treatment and that admission to hospital was not often necessary. By such visits, particularly among those living in rural areas and those known to be indigent, the number of hospital admissions has been decreased, and hospital beds reserved for those who really need that type of care.

County Medical Care Programs in Depression Years

Almost in despair during the dark days of financial depression, several health officers developed medical care programs for the indigent in their counties. For example, in Washington County, the County Medical Society, in conjunction with the County Health Department, operated the following plan:

If an indigent individual or a member of his family requested a physician, the call was referred to the office of the county health department by day, or to the local hospital by night. In either case a public health nurse was sent to the home. Upon arrival, the nurse took the temperature, pulse, respiration and otherwise formed an opinion as to the necessity for summoning a physician. If that need was apparent, a physician was summoned from a list of those who had agreed to respond to such calls. If the first physician could not be reached or was not available, the next on the list was called. In the meantime the nurse was authorized to render first aid, if necessary. If a patient were a member of a family known to be receiving relief and his condition did not require the immediate attention of a physician, the nurse was permitted to administer such simple remedies or give such advice as was indicated. If the nurse found it advisable to summon a physician, the latter, upon arrival, assumed full responsibility for the subsequent management of the case.

Discussion of Program

Although physicians in Washington County received no compensation for care of indigent patients, the program functioned reasonably well for about one year.

Before the plan was adopted, several objections were raised. For example, it was thought that a nurse should not be asked to assume responsibility for deciding whether a physician should be called, and it was questioned whether a nurse should be permitted to administer any kind of treatment. In practice, however, it was found that the nurses did not fail, so far as is known, to call a physician when needed.

Objections to the plan which subsequently developed included (a) the absence of payment for services while physicians in other counties and states were being compensated for the treatment of the indigent, (b) emergency treatment only was provided, and the difficulties of securing medical care for the chronically ill and the less emergent cases continued as usual, and (c) physicians reported that there was a tendency for indigent patients to adopt as the "family" physician, the practitioner who answered the emergency call. On the other hand, the plan made it possible to reduce the number of unnecessary calls of physicians to the homes of the indigent. When a physician was summoned by a public health nurse, he answered the call willingly, even at night, because he knew that his services were really necessary.

In nearly every county the health officer expressed profound regret that a State-wide plan for providing medical care for the indigent had not yet been developed.

Clinics and Equipment in the County Health Department

In each county health department it was found that activities of various types including orthopedic, venereal disease, tuberculosis, immunization and dental clinics were conducted routinely. It was also learned that the health department was the only public agency, other than the hospital, which was staffed and equipped for these purposes. If it should subsequently be decided to establish county centers for treatment of the indigent, it would seem logical, in the interests of economy and efficiency, to utilize these established agencies. Additional space, equipment and personnel would be required to expand these facilities in order to treat the indigent and to serve as a center for the reception of calls and their referral to local physicians.

With the above potentialities in mind, estimates were made of the capacity of the present facilities and of the probable costs of expansion of each department. The present quarters, with comparatively few changes would probably serve the purpose in Anne Arundel, Baltimore, Caroline, Charles, Dorchester, Harford, Howard, Kent, Somerset, Talbot, Washington, and Wicomico Counties. At least one room should be added in Calvert, Carroll, Cecil, Frederick, Garrett, Prince George's, Queen Anne's, St. Mary's and Worcester counties, and a minimum of two rooms would be required in Allegany and Montgomery counties.

In all counties additional equipment would be needed, the amount varying with the size of the county. The following personnel also would be required, (a) a county director, with an assistant director in the larger counties, (b) one or more nurses, (c) a medical social worker in most of the counties, (d) an additional laboratory worker in the branch laboratories and (e) one or more clerks. The employment of part-time clinicians would, of course, be essential to conduct the clinics.

Estimates of the costs of additional space, equipment and personnel will be found in Chapter IX.

Summary

In 1940, a total of 27 public health officers, 100 public health nurses, 30 sanitary inspectors and 35 clerks, as well as other personnel, were full-time employees in the county health departments.

The staff of a typical county health department was composed of the county health officer, two or more public health nurses, a sanitarian, and one or more clerks. Each department conducted a generalized public health program including communicable disease control, public health nursing, preschool and school health service, maternal and child hygiene, services for crippled children, mental hygiene clinics and other activities. In addition, a bacteriological laboratory service is provided in eight counties covering the entire State.

The maintenance of the county health departments was financed jointly by the State Department of Health and city and county governments and other agencies. Personnel were appointed on a merit basis, regardless of whether the salaries were provided from State or local funds, or both.

The budget of the State Department of Health in 1940-41 totalled $1,978,221 of which $533,965, or 27.0 percent, was expended in the 23 counties. Of the latter amount, the sum of $212,259, or 39.8 percent, was received from State and/or Federal sources, while $196,783, or 36.8 percent, was appropriated by city and county governments, and $124,923, or 23.4 percent, was obtained from other agencies.

Of the total for all counties, $533,965, the average budget was $23,216 per county. The average cost for all counties was $0.58 per capita, and the local appropriations totalled $196,783, or an average of $8,556 per county.

Since the number of personnel in the county health departments did not vary greatly, the cost per capita was larger in the counties having relatively small populations. In general, the appropriations by local agencies were larger in the most populous counties and in those in the higher economic levels.

The typical county health officer possessed degrees both in medicine and in public health, and had served in the county for at least ten years.

A number of county health officers reported that a proportion of the population had difficulty in securing medical attention, the percentage varying in magnitude with fluctuations in economic conditions.

The indigent or medically indigent individual seeking medical care, usually applied first to private practitioners, then to the county health department, the local hospital, the county welfare department, or the county commissioners in the sequence indicated.

County health officers asserted that they have been obliged to assume an ever increasing responsibility in arranging for medical care for the indigent and the near indigent.

In an analysis of 813 requests for medical care received by eight county health departments, the findings were as follows:

1. Females constituted a slightly higher proportion of applicants than males.

2. There was a higher proportion of children than adults.
3. About 20 percent were "on relief", while the remaining 80 percent were *not* beneficiaries of county welfare departments.
4. The majority of applications were made by patients, their relatives or neighbors, only a small proportion was referred by county welfare departments.
5. A high percentage of applicants claimed that they had a family physician and asserted that he had been called upon before application was made to the health department.
6. Approximately 60 percent of the applicants were hospitalized, 30 percent were treated by the county health department, and 10 percent were referred to private physicians, who as a rule, were friends of the county health officers or nurses.
7. An accurate estimate of the number of medically indigent in all the counties of Maryland could not be made from the data available. The number of requests for medical care received, however, substantiated reports that a significant number of individuals were constantly requesting county health departments to provide medical care.

The county health departments appear to have prevented a number of unnecessary admissions to hospitals.

The need for a plan for medical care of the indigent was frequently expressed by county health officers.

A variety of clinical activities was conducted routinely in the county health departments. It is suggested that it seems logical to utilize these established agencies, if it should subsequently be decided to organize county facilities for the medical care of the indigent. Additional space, equipment, and personnel that would be required have been listed.

Chapter VIII

WELFARE DEPARTMENT SERVICES

Types of Assistance

In the relief program administered by the State and county departments of welfare, there were provisions for two types of assistance*, (1) classified and (2) general.

1. *Classified assistance included the following categories:*

(a) Aid to Dependent Children

(b) Old Age Assistance

(c) Public Aid to Needy Blind

In these categories the operating funds were derived from "matched" Federal and State sources.

2. *General assistance included but one category:*

(a) General Public Assistance.

In this category funds were obtained from State and local sources.

The conditions under which assistance could be granted in the various categories were defined by law. A summary of these terms is presented below.

1. *Classified Assistance:*

(a) *Aid to Dependent Children*

This category provided care for children whose wage earning parents were temporarily or permanently incapacitated. Medical certification of physical disability of the parent was required.

In Garrett County, and occasionally in other counties, a certificate of physical disability was obtained from the county health department. In the majority of counties, however, this statement was secured from the attending physician.

In Cecil and Kent counties, the county welfare departments compensated the physicians directly for making these examinations. In other counties the disabled parent was expected to pay the physician. The cost of the examination was usually $1.00. Few individuals, however, could pay even this small amount, otherwise they would not have found it necessary to apply for assistance. In some cases this fee was paid by the family with the proceeds of the first check received from the county welfare department.

In all counties re-examination was required every six months, except when the continued existence of the disability was obvious to the casual observer.

(b) *Old Age Assistance*

To be admitted to this category, a person must have been 65 years of age, a citizen of the United States, and a resident for at least one year in the county in which his application was filed. He must have demonstrated the need for financial assistance. As a rule, no physical examination was necessary, except in Allegany, Calvert, Harford, St. Mary's and Washington counties in which the applicant was required to present a certificate of physical disability as proof of need if it appeared that he was employable or employed. As a rule, the county welfare department assumed no obligation for payment for this examination, the applicant being expected to compensate his family physician.

(c) *Public Aid to Needy Blind*

An opthamological examination was a prerequisite for admission to this category. In twenty-one counties these examinations were made at the Wilmer Clinic of the Johns Hopkins Hospital in Baltimore. The county welfare departments usually provided transportation while the State Welfare Department paid the cost of examinations. In Montgomery and Prince George's counties this service was rendered by the Episcopal Eye, Ear, Nose and Throat Hospital in Washington, D. C.

2. *General Assistance*

(a) *General Public Assistance*

This category was provided for persons who were temporarily or permanently incapacitated, but who were not eligible for admission to any other classification. As a rule, a medical certificate was not required, since applicants either were under the care of a physician, or application for assistance had been made in order to obtain medical attention. In certain counties, it was possible for persons in this category to receive medical care since provisions were made for direct compensation of both physicians and hospitals. These counties included Allegany, Anne Arundel, Worcester, Frederick, Kent, Wicomico and possibly others.

Usual Procedures for Securing Assistance and Medical Care

The financial resources of each household were studied by the county welfare department, and a budget prepared in which the family income, if any, was augmented each

*Persons in financial distress in the counties of Maryland were described in various terms "those on relief", "relief clients", "welfare cases", and "those receiving assistance". The latter was most frequently used by county welfare departments.

month by an amount necessary to maintain life at a level "compatible with decency and health". The standards varied from county to county. In some areas which were more "relief minded" and in those in which the cost of living was higher, the families received a larger monthly check.

The procedure for securing medical care for recipients of assistance varied with the type of medical service required: (1) in the home, (2) nursing care, (3) hospitalization, (4) obstetrical care, (5) clinic service, and (6) dental care.

1. *In the home*

The source of medical care in the home was, of course, the family physician. In some indigent families, particularly those who had recently taken up residence in the county, a family physician had not been selected. In such families difficulty in securing a physician frequently was reported. In a number of counties public health nurses were called to the home to investigate reports of illness when a physician was not available.

2. *Nursing Care*

It was unanimously agreed by county welfare executives that the services of a registered nurse rarely, if ever, could be obtained for indigent patients because of the cost. In many of the counties there was no provision for any kind of bedside nursing. In Caroline, Garrett, Howard, Kent, Queen Anne's, St. Mary's, Talbot, and Worcester counties the county welfare department secured the services of a "practical" nurse, if such a person and the funds were obtainable. The urgent need for the organization of a bedside nursing service for recipients of relief was emphasized by every county welfare executive.

3. *Hospitalization*

When an indigent individual required hospitalization, welfare department workers followed one of the procedures outlined below:

(a) Arrangements were made directly with the local hospital or with an institution in the City of Baltimore. This was the routine practice in Calvert, Caroline, Frederick, Kent, Prince George's, and Talbot counties.

(b) Certification of the need for hospitalization and indigency of a patient was made to the county commissioners or other official agency that contracted with the hospital. This was the procedure in Allegany, Garrett, Montgomery, St. Mary's, Somerset and Worcester counties.

(c) The county health departments were requested to make the necessary arrangements in Anne Arundel, Baltimore, Charles, Harford, Howard, Queen Anne's and Washington counties.

It was pointed out by welfare executives that the county welfare departments were usually without funds for hospitalization and that individuals almost invariably were referred to hospitals with the implied understanding that the cost would be met by appropriations for the treatment of free patients received from the State and/or local governments. Occasionally, payments were made to hospitals in the form of checks payable to recipients of old age assistance. The amounts usually were small and were regarded as payment for board and lodging. If such an arrangement could not have been made in at least one hospital, it would not have been possible to secure the admission of these patients.

In attempting to hospitalize indigent persons in institutions in the City of Baltimore, both county welfare and county health departments declared that it was not unusual to be compelled to make four or five long distance calls before accommodations could be found. The need for a central hospital admitting service was emphasized.

4. *Obstetrical Care*

In a few counties in which arrangements had been made for payment of physicians, little difficulty was experienced in obtaining obstetrical care for indigent patients in the home. In other counties this was a serious and constant problem.

In nearly every hospital, except Frederick Emergency, it was almost impossible to hospitalize a *normal* free obsretrical case. In a few counties, it was asserted, the patient had to be "almost dead" before admission could be obtained even for an abnormal case. According to welfare executives, it was contended by hospitals that if a single normal case were admitted, it would be necessary to accept *every* normal case, and the "entire hospital soon would be filled with obstetrical patients."

In all counties a small proportion of mothers postponed application for medical care until delivery was imminent or had already taken place. In instances of this kind the greatest difficulties were encountered. In some cases it was impossible, according to welfare executives, to induce a physician to assume responsibility for care of the case and, if the patient could not be hospitalized, public health nurses not infrequently were called upon to render assistance.

5. *Clinic Service*

The clinics conducted by the county health departments were reported by county welfare executives to have been of great assistance in obtaining diagnoses or treatment for such conditions as tuberculosis, syphilis, the psychoses and deformities. Welfare executives expressed keen regret that general medical and surgical clinic services were not provided.

6. *Dental Care*

The procedures for securing dental care for recipients of relief differed little from those employed in obtaining medical care.

In the school dental clinics which were conducted in several of the more wealthy counties, the children of medically indigent parents received certain types of dental service. In Washington County, and to a very limited extent in several other counties, the county health departments maintained dental service for indigent adults. In Montgomery County the County Commissioners assumed responsibility for paying for this service.

The county welfare departments undertook to secure dental care for those receiving assistance in the same manner as that utilized in obtaining medical attention in Allegany, Anne Arundel, Caroline, Carroll, Cecil, Dorchester, Frederick, Garrett, Howard, and Prince George's counties.

Individuals made their own arrangements for dental care in Baltimore, Charles, Howard, Kent, Queen Anne's, St. Mary's, Somerset, Talbot, Wicomico and Worcester counties.

Except in the school clinics, the dental care of indigent persons was almost exclusively limited to the emergency type.

Selection of Physicians and Authorization of Service

In all counties recipients of assistance had full freedom of choice of physicians. Any individual who applied to the county welfare department for medical care, was urged to call his family physician. Only after it was found that a physician could not be reached, or that none could be induced to accept the case, did the welfare department endeavor to secure medical care from other sources, it was asserted.

In the few counties in which plans for payment of physicians were operating*, the heads of households were expected to receive authorization from the county welfare department before calling a physician. In emergencies occurring on Sundays and holidays, the head of the household was permitted to call the physician directly.

Financial Provisions for Medical Care

The budget of the State and county welfare departments for the year 1942 will be found in Table 43, page 53. The total, which included expenditures both in the counties and in Baltimore City, was $10,880,783. Of this amount, $3,048,913, or 28.0 percent, was allocated for Aid to Dependent Children; $4,192,636, or 38.5 percent, for Old Age Assistance; $193,676, or 1.8 percent, for Public Aid to Needy Blind; $2,202,422, or 20.2 percent, for General Public Assistance; while $1,243,136, or 11.4 percent, was estimated as administrative costs.

The number of households receiving assistance from the various categories of assistance in the counties of Maryland has been shown in Table 44, page 54. The total households assisted in Baltimore City was 15,313, while in the total counties, it was 14,303. It will be observed that in Baltimore City the number in General Public Assistance alone and in combination with other categories was 6,745, or more than three times greater than in the total counties in which there was a total of 1,903. On the other hand, the number of households in the total counties was significantly greater in the categories of Old Age Assistance and in Aid to Dependent Children.

Expenditures for Medical Care

Since a tabulation of expenditures for medical care for the year 1940 was not available, attempts were made in several county welfare departments to determine the proportion devoted to that purpose. At least one hundred records were studied only to find that in about one quarter of the cases the expenditures for medical care were not itemized, but combined with other items. It was also found that it would be exceedingly difficult, if not impossible, to obtain precise information upon this point, which was regarded as a very important one in relation to the subject of this report.

TABLE 43

BUDGET OF THE STATE AND COUNTY WELFARE DEPARTMENTS FOR THE STATE OF MARYLAND FOR THE YEAR 1942.

Categories of Assistance		Total	Percent of Total
(a) Classified	(i) Aid to Dependent Children	$ 3,048,913	28.0
	(ii) Old Age Assistance	4,192,636	38.5
	(iii) Public Aid to Needy Blind	193,676	1.8
(b) General	(i) General Public Assistance	2,202,422	20.2
(c) Administration			
	(i) State Department	160,357	1.5
	(ii) Local Units	1,082,779	9.9
Total		$10,880,783	100.0

The financial provisions for medical care for recipients of relief were said to be limited by the Federal Social Security Law, which charged the State and county welfare departments with the duty of providing the "minimum subsistence compatible with decency and health". Because

*All specific authorization for medical care has since been discontinued in Social Security categories, because of Federal objection.

of legal and financial limitations, welfare executives were forced to regard medical care as one of the necessities of life beyond the purview of their program.

Agreements for Procuring Medical Care

So far as could be determined, no clearly defined Statewide policy had been formulated for securing medical care. Responsibility for establishing procedures was placed on the shoulders of the county welfare departments. As a preliminary step most county welfare executives attempted to secure a formal agreement with the county medical society and the county health department. The extent to which such arrangements could be reached depended in no small measure upon the usual working relationships with these organizations. In Anne Arundel, Garrett and Washington counties agreements were effected. In Anne Arundel County the county medical and dental societies and the local hospital participated as well as the county health department. In these counties a committee representing each participating group met at appropriate intervals and, whenever possible, adjusted difficulties arising in connection with the operation of the agreements. In one of the counties the plan functioned for about three months, in another for approximately six months, and in Anne Arundel County the agreement was still in operation at the conclusion of the field survey on September 15, 1941.

The county welfare executives in twenty counties declared that after it was found that formal agreements with the organized medical profession and other health agencies could not be obtained, informal arrangements were sometimes made with individual physicians. Welfare executives stated that, in general, they relied principally upon the cooperation of a relatively small number of physicians and dentists who always could be depended upon to respond to calls for assistance.

Plans for Payment

A summary of plans developed by the county welfare departments to compensate physicians for medical care in the home will be found in Table 45, page 56. It will be noted that two general methods of financing medical care were employed, either singly or in combination:

(1) A fixed sum, varying from 50c to $3.50 per family was allotted each month for medical service.

TABLE 44

UNDUPLICATED NUMBER OF HOUSEHOLDS RECEIVING ASSISTANCE FROM THE VARIOUS CATEGORIES OF ASSISTANCE IN THE COUNTIES OF MARYLAND IN JUNE, 1940.

County	Total	OAA Only	ADC Only	PANB Only	GPA Only	Various Combinations of OAA, ADC and PANB	GPA and Other
State of Maryland	29,616	16,097	3,978	579	5,598	314	3,050
Baltimore City	15,313	6,871	1,243	348	4,113	106	2,632
Total Counties	14,303	9,226	2,735	231	1,485	208	418
Percent	100%	64.5%	19.1%	1.6%	10.4%	1.5%	2.9%
Allegany	1,288	696	244	24	184	18	122
Anne Arundel	605	369	126	14	71	10	15
Baltimore	1,049	768	136	20	44	10	71
Calvert	229	149	44	2	31	2	1
Caroline	464	341	73	8	35	6	1
Carroll	468	345	46	6	59	3	9
Cecil	554	339	118	10	54	9	24
Charles	335	227	76	5	24	3	—
Dorchester	717	541	91	13	54	13	5
Frederick	745	445	201	12	70	8	9
Garrett	583	336	105	7	124	5	6
Harford	523	361	62	5	80	4	11
Howard	307	219	53	2	28	4	1
Kent	281	209	29	11	24	3	5
Montgomery	709	420	148	14	96	14	17
Prince George's	749	408	144	9	117	18	53
Queen Anne's	400	287	69	8	23	9	4
Saint Mary's	384	222	122	2	34	4	—
Somerset	637	397	182	13	38	3	4
Talbot	412	343	38	7	21	3	—
Washington	1,378	773	316	25	191	21	52
Wicomico	1,000	657	224	7	82	22	8
Worcester	486	374	88	7	1	16	—

The amount was added to the monthly check received from the welfare department. It was expected that each monthly allotment would be saved for use in a medical emergency.

(2) The monthly check of the family was supplemented by the amount of a specified medical obligation incurred within the month. If the total were more than was available in the surplus funds of the county welfare department for that month, payment of the obligation was pro-rated over a number of months.

The first method was used in Allegany County where $1.00 per month was allocated to the family and no other funds were available. It also constituted the principal form of payment in St. Mary's County. With some variations this procedure formerly was used in Calvert, Cecil and Worcester counties.

In St. Mary's County a "pool" was organized by the county welfare department. One dollar was collected each month from recipients of relief. These amounts were pooled and physicians paid therefrom for services rendered the participating families. This plan operated for a few months and, it was reported, seemed to be going well when it was found the county welfare departments were not permitted to conduct such an activity and, therefore, it was discontinued.

In the remaining counties the second method of financing medical care, that of supplementing the monthly check, was employed.

Financial Arrangements with Physicians

The head of the household was encouraged to make arrangements for medical care directly with the physicians, because it was desired that the former should learn to manage his own financial affairs and also because it was found that an indigent individual usually was able to make a "better bargain" with physicians than the county welfare department. When agreement as to the probable cost of treatment had been reached between the head of the household and the physician, the county welfare department was so informed. If the expense involved was found to be greater than the amount that might "properly be allocated" for the purpose, or if the funds of the county welfare department were low, the physician was requested by the welfare executive to reduce his fee. The limit of the amount that might "properly be allocated" seemed to be left to the discretion of the welfare worker since, so far as could be determined, no standard had been set.

In several counties when the monthly check was increased to provide for settlement of a specific medical obligation, the physician was informed, as a matter of courtesy. This was as far as county welfare departments appeared to have gone in aiding in the payment of bills. Many executives stoutly maintained that a county welfare department was *not* a collecting agency. Welfare executives also expressed the belief that physicians seldom had difficulty in making collections if serious attempts were made to do so, and that among those receiving assistance the proportion of persons who paid their bills was no less than among the general population.

Physicians' Fees

Physicians' fees were practically the same in all rural areas; office visits, $1.00; home calls $2.00 within three miles of the office, and a minimum of $3.00 when the distance was greater. In towns over 10,000 population, the fees were higher. The cost of obstetrical services varied from $10.00 to $25.00 and included, as a rule, delivery and one or two post-natal calls.

Opinions on the Availability of Medical Care

Each executive was asked the question, "Are there persons in the county who, because of lack of sufficient funds, are unable at times to obtain medical care?" In the twenty counties the answer was "Yes". In twelve of these the executives asserted that many persons with chronic illnesses were at time unable to obtain medical care, while more than a few with acute illnesses also were in that category. In eight counties the executives were of the opinion that only a relatively small number of persons were unable eventually to secure medical attention.

In all of the twenty-three counties the welfare executives expressed the opinion that there was a considerable number of persons who, because of lack of money or credit, sometimes delayed calling a physician even past the danger point.

Medical Care Problems Outlined by Welfare Executives

All welfare executives declared that the problem of securing adequate medical care for those receiving assistance was one of the most difficult and important extant. The following specific deficiencies were presented, with suggestions as to their correction:

1. *A general lack of understanding of relief problems on the part of local physicians and a few county health departments.*

Most executives agreed that, so far as the physicians were concerned, adjustment of fees and a change in the method of paying them undoubtedly would go far in reaching a solution of this problem.

2. *A lack of adequate diagnostic and treatment facilities in the county health departments.*

In twelve counties this defect was repeatedly mentioned. Services specifically requested included general medical and surgical clinics, mental hygiene clinics and dental clinics—particularly for dental treatment of adults.

3. *The absence of hospital facilities for treatment of the chronically ill.*

The erection of a hospital or, if necessary, a number of institutions for treatment of the chronically ill was strongly advocated.

4. *The absence of any kind of bedside nursing service.*

In six of the counties, executives pointed out that the lack of visiting nurses and "practical" nurses for home care of patients was a serious deficiency. If such services were available, suffering of many patients, in the opinion of the executives would be alleviated and recovery hastened.

5. *A lack of adequate medical care for the low income group.*

Many executives expressed the belief that in addition to those now receiving assistance, there were numerous others in the low income group who were suffering for lack of adequate medical care. Particular reference was made to those who were "too proud to accept anything that might be regarded as charity and preferred to continue to suffer in relative silence". In several counties, a fairly large proportion of the population—sharecroppers, farmhands, fishermen and the like—received wages that barely were sufficient to purchase the absolute necessities of life. The welfare departments were not permitted to assist persons

TABLE 45

SUMMARY OF PROCEDURES USED BY COUNTY WELFARE DEPARTMENTS TO COMPENSATE PHYSICIANS FOR MEDICAL CARE IN THE HOME

Counties of Maryland	Amounts Added Each Month to Family Check	Amounts Added to Family Check Only After Illness Developed
Talbot	$0.50 per person in family to maximum of $3.50	Amount agreed upon by physician, patient, and welfare executive.*
St. Mary's	$1.00 Minimum and $2.00 maximum depending on size of family	None
Garrett	$1.00	Amount agreed upon by physician, patient, and welfare executive.*
Frederick	$0.50	Amount agreed upon by physician, patient, and welfare executive.*
Allegany	$1.00	None
Anne Arundel Calvert Caroline Carroll Dorchester Queen Anne's Somerset Wicomico Worcester	None	Amount agreed upon by physician, patient, and welfare executive.*
Cecil Charles Harford Howard Prince George's Kent*	None	In acute case, amount agreed upon by physician, patient, and welfare executive.* In chronic cases, amount varied with doctor's statement of need.
Baltimore	None	None

*In most counties the total amount of the bill was pro-rated over a period of months so that the "legal limits" of the clients, budget would not be exceeded

in this class since their incomes were regarded as being slightly above "the minimum compatible with decency and health".

Suggested Solutions for Problems

In thirteen counties welfare executives favored the development of a "well-controlled plan" for public payment for medical care. In four counties, it was felt that the present plan was operating satisfactorily. In the remainder, no comments were elicited. Of those who ventured an opinion on this subject, twelve favored a cooperative program between the county welfare and county health departments. One suggested the formation of a new organization. All except two expressed the belief that the benefits of such a plan also should be extended to families in the low income brackets. Under any plan, welfare executives believed that those receiving assistance should always, "within reason", have the right to choose their own physician.

All except two of the twenty-three executives believed that physicians should receive the same fees for the treatment of recipients of relief as for private patients.

Summary

The categories of assistance for indigent persons included: Aid to Dependent Children, Old Age Assistance, Public Aid to Needy Blind, and General Public Assistance. Except for Public Aid to Needy Blind, there were no uniform provisions for physical examinations for determination of eligibility for relief or for compensation of the examiners.

Important and urgent needs outlined by county welfare executives included: an organized bedside visiting nurses service, a central hospital admitting service, a larger number of hospital beds for normal obstetrical cases, general medical and surgical clinics in county health departments, dental clinics for indigent adults.

It was found that recipients of relief had free choice of physicians.

For the year 1942, the total budget of the State and county welfare departments was $10,880,783, of which 28.0 percent was allocated for Aid to Dependent Children, 38.5 percent for Old Age Assistance, 1.8 percent for Public Aid to the Needy Blind, 20.2 percent for General Public Assistance, and 11.4 percent for Administration.

An accurate estimate of the proportion spent for medical care could not be obtained.

A total of 14,303 households received assistance of which 64.5 percent were in Old Age Assistance, 19.1 percent were in Aid to Dependent Children, 1.6 percent in Public Aid to Needy Blind, 10.4 percent in General Public Assistance, and 2.9 percent in a combination of General Public Assistance and other categories.

There did not appear to be a well-defined State-wide policy for procuring medical care for those receiving assistance.

In each of three counties, formal agreements for providing medical care for indigent patients were reached between the county welfare department, the county medical and county dental societies and the county health department. In only one of these did the agreement continue to function for more than six months. In other counties the county welfare executives sometimes made informal agreements with individual physicians.

Two general methods of financing medical care were employed either alone or in combination (a) an amount ranging from $0.50 to $3.50 per family was added to the monthly check, with the expectation that it would be "saved" to pay for emergency medical services, and (b) the monthly check was augmented, whenever sufficient funds were on hand, to pay for a specific medical obligation.

Heads of households were encouraged to make their own financial arrangements with physicians.

In rural areas, physicians' fees, as a rule, were $1.00 for office calls, $2.00 for home calls under 3 miles, and a minimum of $3.00 for greater distances. Charges for obstetrical cases varied between $10.00 and $25.00 per case.

Twenty welfare executives stated that there were persons in their respective counties who, because of lack of sufficient funds, were unable at times to obtain medical care. Twelve executives asserted that many persons with chronic illness were at times unable to obtain medical services.

In all 23 counties, welfare executives believed that there was a considerable number of persons who, because of lack of money or credit, sometimes delayed calling a physician even past the danger point.

Welfare executives, cognizant of the need for expanding medical services not only for the benefit of those receiving assistance, but for the marginal income group, suggested the following procedures (a) the adjustment of physicians' and dentists' fees and a change in the method of paying them, (b) expansion of the diagnostic and treatment facilities in the county health department, especially the establishment of general medical and surgical clinics and dental clinics, particularly for the treatment of adults, (c) the erection of chronic disease hospitals, (d) the organization of a bedside nursing service.

Twenty-one executives expressed the opinion that physicians should receive the same fees for treatment of recipients of relief as for private patients.

Welfare executives favored the retention of the right of those receiving assistance to select their own physician, and to negotiate with him directly both in seeking and paying for professional services.

Chapter IX

THE SCOPE AND COSTS OF A MEDICAL CARE PROGRAM

In a program for medical care the following are basic considerations:

1. The number of beneficiaries
2. The frequency of illness and the volume of medical care
3. The character of the medical services
4. The costs of operation

1. THE NUMBER OF BENEFICIARIES

(a) *The Number of Indigent in the Counties in 1940*

(i) *The number receiving assistance*

The households receiving assistance from the county welfare departments in 1940 included only those in which none was employable, that is to say, that there was no individual who was physically fit and between 17 and 65 years of age.

In Table 46, page 59, it will be noted that there were 14,303 households and 50,060 individuals receiving assistance, assuming that there was an average of 3.5 persons per household. The number of individuals varied from 801 in Calvert to 4,823 in Washington County, with a rate of 23.6 per 1,000 population in Baltimore and 106.4 in Somerset County. For the total counties the rate was 52.0 persons per 1,000 population.

(ii) *The number employed by the W. P. A.*

In 1940 in indigent families in which there were one or more employable persons, work was usually provided for at least one of them by the Works Projects Administration, a Federal works agency, in which the worker received approximately $45.00 per month. From this amount the family was expected to pay all living expenses, including those for medical care. With a total income of about $540 per year, such medical care as could have been paid for, if any, must have been strictly limited to acute emergencies.

In the total counties the number of persons employed and awaiting employment in the W.P.A. during the week of June 19, 1940, was 9,333, representing an estimated total of 32,666 individuals. In Kent and Calvert counties there were no persons in this group, as shown in Table 47, page 60. In Baltimore and Talbot counties 98 individuals were represented, while there were as high as 8,694 persons in Allegany County. The rate per 1,000 population, except in Kent and Calvert counties, ranged from 0.6 in Baltimore to 124.7 in Garrett County. For the total counties the rate was 33.9 persons per 1,000 population.

(iii) *The total receiving assistance and employed by the W.P.A.*

For all counties a total of 82,726 individuals received assistance and were represented in the W.P.A. group, of whom 801 were in Calvert and 13,202 in Allegany County, as will be seen in Table 48, page 61. The rate was 24.2 in Baltimore and 217.5 per 1,000 population in Garrett County. For the total counties the rate was 86.0 per 1,000 population. The above data may be summarized as follows:

	Households	Individuals	Number Per 1,000 Population
Direct relief	14,303	50,060	52.0
W. P. A. employees	9,333	32,666	34.0
Total	23,636	82,726	86.0

In estimating the total number of individuals that should be provided for in a partly or wholly tax-supported program for medical care, it is taken for granted that both the above groups should be included[1].

Classification of Counties

The proportion of the population which has been supported wholly or partially by tax funds has varied from year to year, reaching a peak in 1940. The distribution of 82,726 individuals in this class in that year is shown in Table 49, page 61, by counties arranged in order of magnitude. It will be observed that the counties have been divided into three groups in which the toral indigent varies from (a) 0-2,499, (b) 2,500 to 4,999, and (c) 5,000 individuals or more. It is obvious that the frequency of illness and the volume of medical care as well as other factors vary with the number of persons involved. In the remainder of this Chapter, therefore, the counties will be classified in these three groups.

[1]In 1940, the Civilian Conservation Corps, another Federal works agency, provided employment in a number of counties of Maryland for 2,427 youths from 17 to 23 years of age. A large proportion of the wages of these youths augmented the income of a family receiving assistance or one in which another member was employed by the W.P.A. These individuals were not included in the total for whom medical care should be provided, because in most instances, if not all, they had already been counted.

The Medically Indigent Not Included in Calculations

An *indigent* person has been defined as a member of a household receiving or eligible to receive assistance from a county welfare department, while a *medically* indigent individual is one who is able to pay the cost of occasional minor illness, but unable to pay expenses involved in a severe or prolonged disability.

It has been repeatedly brought to the attention of the Committee by many persons in the counties of Maryland that in any plan for medical care provision should be made for assisting not only the indigent, but also the *medically* indigent . . . "a good, hard-working man with a family who ordinarily pays his bills but who is overwhelmed when overtaken by illness in himself or in his family."

In calculating the number of beneficiaries in a medical care program for the Counties of Maryland, persons of this type have *not* been included because no acceptable estimate of their number is at present available.

The Committee believes that information of this type for the counties of Maryland could best be obtained by a more detailed survey, or by trial of a program including provisions for the medically indigent in one or more counties or even on a State-wide basis.

Calculations upon which the program is based included the estimated medical needs of an entire population. In Maryland it is proposed that only the indigent would be served. At first, the latter might not and probably would not use all services for which provision has been made. Furthermore, it would be impracticable to set up a complete system within a year or two. If the total recommended appropriations were made, the balance during the first biennium could be utilized for care of the medically indigent, or at least for obtaining estimates of their distribution.

2. THE FREQUENCY OF ILLNESS AND VOLUME OF MEDICAL CARE

The frequency of illness and the volume of medical care were recorded by Collins[1] for a twelve-month period between 1928 and 1931 by periodic canvasses of 8,758 white families in 130 localities in 18 states. Illnesses causing symptoms that lasted one day or longer were recorded, together with the number of doctor's calls on the case. The surveyed families included representation from all geographic sections, from rural, urban, and metropolitan areas, from all income classes, and both native and foreign born persons.

The recorded illness from all causes amounted to 829 cases per 1,000 persons. Of the total cases, 79 percent were attended by some type of practitioner, a rate of 647 attended cases per 1,000 population. On this basis, among the 82,726 individuals in the counties of Maryland for whom a medical care program is outlined, there would have been 68,580 cases of recorded illness, of which 53,524 would have been attended by some type of physician.

In Collins' series, 526 attended cases per 1,000 were treated by physicians in general practice. In the Maryland group, therefore, a total of 43,514 cases would have been attended by general practitioners, assuming that the indigent patients would request and receive all the medical care for which the majority of the population were able to pay. The distribution of the theoretical number of attended cases in the counties of Maryland is shown in Table 50, page 62.

Collins found that there were 4.6 calls by all practitioners per attended case with a total of 2,949 calls during the year per 1,000 canvassed population. It was observed that the volume of medical care in terms of doctors' calls per 1,000 population was greater in large cities than in small towns and rural areas. In calculating the theoretical number of

TABLE 46

TOTAL HOUSEHOLDS AND ESTIMATED NUMBER OF INDIVIDUALS RECEIVING ASSISTANCE ASSUMING THAT THE AVERAGE WAS 3.5 PERSONS PER FAMILY; AND THE NUMBER PER 1,000 POPULATION IN THE COUNTY OF RESIDENCE IN JUNE, 1940

County	Total Households Receiving Assistance	Estimated Number of Persons Receiving Assistance (1) x 3.5	Number per 1,000 Population in County of Residence
Baltimore	1,049	3,672	23.6
Prince George's	749	2,621	29.3
Montgomery	709	2,482	29.6
Anne Arundel	605	2,117	31.0
Carroll	468	1,638	42.0
Frederick	745	2,608	45.5
Allegany	1,288	4,508	51.9
Harford	523	1,830	52.2
Howard	307	1,075	62.6
Charles	335	1,172	66.6
Washington	1,378	4,823	70.1
Kent	281	984	73.1
Cecil	554	1,939	73.4
Calvert	229	801	76.5
Talbot	412	1,442	76.8
Worcester	486	1,701	80.1
Dorchester	717	2,510	89.6
Saint Mary's	384	1,344	91.9
Caroline	464	1,624	92.5
Garrett	583	2,040	92.9
Queen Anne's	400	1,400	96.7
Wicomico	1,000	3,500	101.4
Somerset	637	2,229	106.4
Total Counties	14,303	50,060	52.0

[1]Collins, Selwyn D.: Frequence and Volume of Doctors' Calls Among Males and Females in 9,000 Families Based on Nation-wide Periodic Canvasses, 1928-31, Pub. Health Rep., 55:1977-2020 (Nov. 1, 1940) (Reprint 2205).

calls per case in the counties of Maryland, the figure 4.0 rather than 4.6 calls per attended case was used, since there were no large cities in that area. It is thought that the use of even a smaller ratio might be justifiable.

With the estimated total of 43,514 cases attended by private practitioners, the total number of calls, therefore, would have been 174,056. In Table 50, page 62, the number of calls by private practitioners has been calculated by counties.

Distribution of Calls

In a study by Ciocco and Altman[1] the average weekly patient load of white male practitioners was indicated for Maryland, exclusive of Baltimore City. From these data, it was estimated that the physicians' services were distributed as follows:

Office calls	73%
Hospital calls	5%
Home calls	22%

TABLE 47

TOTAL PERSONS EMPLOYED AND AWAITING EMPLOYMENT IN THE WORKS PROJECTS ADMINISTRATION IN THE COUNTIES OF MARYLAND FOR THE WEEK ENDING JUNE 19, 1940, THE ESTIMATED NUMBER OF INDIVIDUALS IN THE HOUSEHOLDS—ASSUMING THAT FOR EACH PERSON EMPLOYED THE NUMBER IN EACH HOUSEHOLD AVERAGE 3.5 PERSONS; AND THE NUMBER PER 1,000 POPULATION IN COUNTY OF RESIDENCE, BY RANK.

County	Total Employed and Awaiting Employment in in the W.P.A. (Week of June 19, 1940)	Total Individuals Represented (Average 3.5 Per Person Employed)	Number per 1,000 Population in County of Residence
Kent	None	—	—
Calvert	None	—	—
Baltimore	28	98	.6
Montgomery	130	455	5.4
Talbot	28	98	5.2
Carroll	142	497	12.7
Cecil	127	444	16.8
Charles	85	298	16.9
Prince George's	496	1,736	19.4
Anne Arundel	390	1,365	20.0
Howard	134	469	27.3
Dorchester	220	770	27.5
Harford	290	1,015	29.0
Caroline	146	511	29.1
Worcester	177	620	29.2
Queen Anne's	122	427	29.5
Saint Mary's	128	448	30.6
Somerset	213	746	35.6
Wicomico	367	1,285	37.2
Frederick	1,140	3,990	69.6
Washington	1,703	5,960	86.6
Allegany	2,484	8,694	100.2
Garrett	783	2,740	124.7
TOTAL	9,333	32,666	33.9

[1]Ciocco, Antonio and Altman, Isador: Statistics on the Patient Load of Physicians in Private Practice, J.A.M.A. 121:506-513 (February 13) 1943.

In Table 51, page 63, the distribution of 174,056 calls of general practitioners has been calculated on the above basis. It will be noted that 127,059 are office calls, 8,704 are hospital calls, and 38,293 are home calls.

Cases Attending Clinics

Of the 53,524 cases that would be attended by some type of medical practitioner, it was estimated that 43,514 cases would receive treatment from general practitioners. In the suggested plan it is contemplated that clinics would be staffed by specialists, and that treatment by physicians not general practitioners would be limited to that received in clinics and in hospitals. It is clear, therefore, that the remainder, 10,010 cases, represents the number that, under the plan, would be expected to attend clinics. With an estimated average of 5 clinic calls per case, there would be a total of 50,050 clinic calls per year. In Table 52 page 64, the distribution of the estimated clinic cases and calls has been shown by counties.

3. THE CHARACTER OF MEDICAL SERVICES NEEDED

The following medical and dental services and equipment are regarded as the minimum essential to the maintenance of a program of medical care for the indigent in the counties of Maryland:

1. Private Physicians
   - (a) General Practitioners
   - (b) Clinicians
   - (c) Consultants
2. Hospitals
   - (a) General
   - (b) Chronic Disease
3. Health Departments
   - (a) Clinic Space and Equipment
   - (b) Visiting Nurses
   - (c) Dentists
   - (d) Clinical Laboratories
4. Administration
   - (a) State
   - (b) County

1. *Private Practitioners Services*

(a) *General Practitioners*

In a number of cities and counties throughout the United States full and part-time physicians are employed by local governments to treat the indigent in their homes and in offices—usually located in the city or county health de-

partment. In areas in this vicinity[1] in which this type of service was investigated a full-time physician seemed to be able to serve fairly adequately the *emergency* medical needs of the indigent. If, however, the population were large and the area extensive, one physician or even several physicians were unable at times to provide adequate emergency service. Moreover, the special services which occupy such an important place in modern medical practice, were not provided except to a very limited extent. We have not found a single instance in which a part-time physician has been able to render a significant amount of medical care for the indigent and at the same time earn a livelihood in the private practice of medicine. To provide adequate treatment, particularly in rural and semi-rural areas which predominate in the counties of Maryland, it seems essential that all or nearly all physicians in private practice should participate in the program.

It is held that each family should have the privilege of selecting its own physician, and conversely, that practitioners should be privileged to decide whether or not they will accept a case.

TABLE 48

ESTIMATED NUMBER OF INDIVIDUALS RECEIVING ASSISTANCE FROM COUNTY WELFARE DEPARTMENTS AND PERSONS IN HOUSEHOLDS IN WHICH ONE OF THE MEMBERS WAS EMPLOYED BY THE W.P.A., TOGETHER WITH THE TOTAL AND NUMBER PER 1,000 POPULATION IN THE COUNTIES OF RESIDENCE.

County	Estimated Number of Individuals Receiving Assistance (1940)	Estimated Number of Individuals in WPA Households (1940)	Total Individuals	Number Per 1,000 Population
Baltimore	3,672	98	3,770	24.2
Montgomery	2,482	455	2,937	35.0
Prince George's	2,621	1,736	4,357	48.9
Anne Arundel	2,117	1,365	3,482	50.9
Carroll	1,638	497	2,135	54.7
Kent	984	None	984	73.1
Calvert	801	None	801	76.5
Harford	1,830	1,015	2,845	81.2
Talbot	1,442	98	1,540	82.0
Charles	1,172	298	1,470	83.5
Howard	1,075	469	1,544	89.9
Cecil	1,939	444	2,383	90.2
Worcester	1,701	620	2,321	109.2
Frederick	2,608	3,990	6,598	115.1
Dorchester	2,510	770	3,280	117.1
Caroline	1,624	511	2,135	121.7
Saint Mary's	1,344	448	1,792	122.5
Queen Anne's	1,400	427	1,827	126.2
Wicomico	3,500	1,285	4,785	138.6
Somerset	2,229	746	2,975	141.9
Allegany	4,508	8,694	13,202	152.1
Washington	4,823	5,960	10,783	156.6
Garrett	2.040	2,740	4,780	217.5
Total	50,060	32,666	82,726	86.0

(b) *Clinicians*

Under the suggested plan, the large majority of patients would receive medical care in their own homes and in the doctors' offices. For ambulatory patients, and particularly for obscure and difficult cases, clinics, staffed by specialists, should be established in the county seat, and possibly in other locations. In these clinics physical examinations of applicants for relief and other activities related to the medical care program might also be conducted.

It is essential that these physicians in charge of clinics should be specialists in their field and that they be selected with the greatest care by competent medical authorities. Whenever properly qualified clinicians are available locally their services should be utilized, otherwise it would be necessary to obtain clinicians from the nearest medical center.

TABLE 49

THE TOTAL NUMBER OF INDIVIDUALS RECEIVING ASSISTANCE FROM COUNTY WELFARE DEPARTMENTS AND THOSE IN FAMILIES IN WHICH THE HEAD OF HOUSEHOLD OR ONE OF ITS MEMBERS WAS EMPLOYED IN THE W.P.A.; AND THE NUMBER PER 1,000 POPULATION IN THE COUNTY OF RESIDENCE.

Total Indigent Persons	County	Persons Receiving Assistance and in Households in Which Head or Other Member was Employed by the W.P.A. (June 19, 1940)	Number Per 1,000 Population
0-2,499	Calvert	801	76.5
	Kent	984	73.1
	Charles	1,470	83.5
	Talbot	1,540	82.0
	Howard	1,544	89.9
	Saint Mary's	1,792	122.5
	Queen Anne's	1,827	126.2
	Caroline	2,135	121.7
	Carroll	2,135	54.7
	Worcester	2,321	109.2
	Cecil	2,383	90.2
2,500-4,999	Harford	2,845	81.2
	Montgomery	2,937	35.0
	Somerset	2,975	141.9
	Dorchester	3,280	117.1
	Anne Arundel	3,482	50.9
	Baltimore	3,770	24.2
	Prince George's	4,357	48.9
	Garrett	4,780	217.5
	Wicomico	4,785	138.6
5,000 & Over	Frederick	6,598	115.1
	Washington	10,783	156.6
	Allegany	13,202	152.1
Total		82,726	86.0

[1]In the States of Virginia and North Carolina.

Types of Clinics

The following types of clinics should be provided in each county:

(i) Internal Medicine

(ii) Surgery

(iii) Obstetrics and Gynecology

(iv) Pediatrics

(v) Ophthalmology and Ororhinolaryngology

Clinic Services Now Functioning

It is taken for granted that the following clinics, established and maintained by the State Department of Health and other agencies would be continued:

(i) *Venereal Disease Clinics* conducted by the State Department of Health. In 23 counties in 1940 a total of 68 clinics, or an average of 3 per county, was operated at least once each week. These clinics were staffed by 62 physicians, almost all of whom were private practitioners who had taken a special interest in the treatment of this type of disease. Approximately 9,000 persons were admitted for diagnosis and/or treatment, and over 83,000 treatments were given.

(ii) *Orthopedic Clinics* were conducted by the State Department of Health in nearly every county. Over 2,300 physically handicapped children were treated in 1940.

(iii) *Tuberculosis Clinics* conducted in most of the counties by the Maryland Tuberculosis Association, in cooperation with the State and County Health Departments. In 1940 over 5,700 persons were examined at the monthly chest clinics.

TABLE 50

THE TOTAL INDIVIDUALS RECEIVING ASSISTANCE AND THOSE IN FAMILIES IN WHICH AT LEAST ONE MEMBER WAS EMPLOYED BY THE W.P.A.; THE ESTIMATED NUMBER OF CASES ATTENDED BY A GENERAL PRACTITIONER ANNUALLY, ON THE ASSUMPTION THAT THERE WERE 526 CASES PER 1,000 POPULATION; AND THE ESTIMATED NUMBER OF CALLS MADE BY PHYSICIANS IN GENERAL PRACTICE, ASSUMING THAT THERE WERE 4.0 CALLS PER CASE.

	County	Total Persons Receiving Assistance and Those in Families in Which One Member was Employed by the W. P. A.	Estimated Number of Cases Attended by General Practitioners (526 Cases per 1,000 Population)	Estimated Number of Calls by General Practitioners (4.0 Calls per Attended Case)
0-2,499	Calvert	801	421	1,684
	Kent	984	518	2,072
	Charles	1,470	773	3,092
	Talbot	1,540	810	3,240
	Howard	1,544	812	3,248
	Saint Mary's	1,792	943	3,772
	Queen Anne's	1,827	961	3,844
	Caroline	2,135	1,123	4,492
	Carroll	2,135	1,123	4,492
	Worcester	2,321	1,220	4,880
	Cecil	2,383	1,253	5,012
2,500-4,999	Harford	2,845	1,496	5,984
	Montgomery	2,937	1,546	6,184
	Somerset	2,975	1,565	6,260
	Dorchester	3,280	1,725	6,900
	Anne Arundel	3,482	1,832	7,328
	Baltimore	3,770	1,983	7,932
	Prince George's	4,357	2,293	9,172
	Garrett	4,780	2,514	10,056
	Wicomico	4,785	2,516	10,064
5,000 & Over	Frederick	6,598	3,471	13,884
	Washington	10,783	5,672	22,688
	Allegany	13,202	6,944	27,776
Total		82,726	43,514	174,056

(iv) *Mental Hygiene Clinics* conducted under the joint auspices of the Bureau of Child Hygiene of the State Department of Health, the State Commissioner of Mental Hygiene, the State Hygiene Society, County Health Departments and Boards of Education. Clinicians were selected from the Srare, Baltimore City or local hospitals and insritutions. In 1940 over 800 persons—670 under 21 years of age—were examined at 101 clinics in 21 counries.

(c) *Consultants*

At all times competent consultants, carefully selected by impartial medical authorities, should be procurable by a private practitioner attending indigent cases.

In mosr counties the clinicians might also serve as consulrants. Other physicians should be appointed to serve in this capacity when clinicians are not available.

2. *Hospitalization*

(a) *General*

In Collins series[1] rhere were during the year 61.6 hospital cases and 886 hospital days per 1,000 persons under observation, exclusive of cases in institutions throughout the year. Among 82,726 persons, rhe estimated number of indigent in the counties of Maryland in 1940, there would, therefore, have been 5,095 hospital cases and 73,295 hospital days.

During the year 1940 a total of 228,346 free hospital days were reported as having been provided for county residents by hospitals in the counties and in Baltimore City for which at least partial compensation was received from rhe State and local governments.

From the above data rhe following deducrions are possible:

Either the dara furnished the Committee were inaccurate, or, indigent patients were provided with more than three times the number of hospital days than were calculated to have been needed, or, a proportion and perhaps a fairly large proportion of the group defined as the medically indigent received free hospitalization. The last of these deductions seems the most likely.

(b) *Chronic Disease*

In addition to hospiralization, it is of the utmost importance that institutions for the treatment of chronic disease be constructed. Further reference to this subject will be found in Chaprer X.

3. *Health Department Services*

(a) *Clinic and Office Space*

Under the proposed program the county health department would provide the following facilities and equipment:

(i) A center for the receprion of calls for physicians and for the hospitalization of indigent patients.

(ii) Quarters for clinics locared whenever practicable in local hospitals.

(iii) Offices for visiting nurses and medical social workers.

(iv) Offices for records and accounting.

(b) *Visiting Nurses Service*

Visiting nurses should be attached to the staff of the county health department with the following duties:

1. Bedside nursing service in the homes.
2. Service in clinics.
3. Public health nursing service when not otherwise engaged.

Serving under the direct supervision of the county health officer in such matters as hours of work and office

TABLE 51

ESTIMATED NUMBER OF CALLS BY GENERAL PRACTITIONERS BY COUNTIES, ASSUMING THAT 73 PERCENT WERE OFFICE, 5 PERCENT HOSPITAL AND 22 PERCENT HOME CALLS

County	Total Estimated Calls	Theoretical Distribution of Calls		
		Office 73%	Hospital 5%	Patient's Home 22%
Calvert	1,684	1,229	84	371
Kent	2,072	1,513	103	456
Charles	3,092	2,257	155	680
Talbot	3,240	2,365	162	713
Howard	3,248	2,371	162	715
Saint Mary's	3,772	2,754	189	829
Queen Anne's	3,844	2,806	192	846
Caroline	4,492	3,279	225	988
Carroll	4,492	3,279	225	988
Worcester	4,880	3,562	244	1,074
Cecil	5,012	3,658	251	1,103
Harford	5,984	4,368	299	1,317
Montgomery	6,184	4,514	309	1,361
Somerset	6,260	4,570	313	1,377
Dorchester	6,900	5,037	345	1,518
Anne Arundel	7,328	5,350	366	1,612
Baltimore	7,932	5,790	397	1,745
Prince George's	9,172	6,696	459	2,017
Garrett	10,056	7,341	503	2,212
Wicomico	10,064	7,347	503	2,214
Frederick	13,884	10,135	694	3,055
Washington	22,688	16,562	1,135	4,991
Allegany	27,776	20,276	1,389	6,111
Total	174,056	127,059	8,704	38,293

[1]Collins, Selwyn D.: Frequency and Volume of Hospital Care for Specific Disease in Relation to All Illnesses Among 9,000 Families Based on Nationwide Periodic Canvasses, 1928-31, Pub. Health Rep., 57:1399-1428 (Sept. 18, 1942) and 57:1439-1460 (Sept. 25, 1942) Reprint 2405.

routine, the visiting nurse would also be responsible to the physician in charge of each case under her care.

(c) *Dental Services*

Dental clinics have been established in a number of counties, as indicated in Chapter V, and it has been shown that this service is seriously handicapped by inadequate funds.

Under normal conditions, it should be made possible to establish and maintain in every county a dental program for the care of the indigent under the leadership of a full-time dentist on the staff of the county health department. In the smaller counties, it is believed that one dentist could conduct the school health program and give a reasonable amount of emergency dental care to adults. In the counties having a larger number of indigent patients, however, there should be at least two dentists, one conducting the school dental health program and the other giving dental care to indigent adults.

(d) *Clinical Laboratory Service*

To provide clinical laboratory service for physicians attending indigent patients in their home and offices, and for patients attending clinics, it would be necessary to procure additional laboratory personnel and equipment. In the interests of economy and efficiency other than operation and administration, it is suggested that this personnel be attached to the staff of the branch laboratories of the State Department of Health, or that arrangements for clinical laboratory service such as are now operative in Charles, St. Mary's and Calvert counties be extended to other sections of the State.

It would be expected that the clinical laboratories in hospitals continue to provide services for the indigent patients in their respective institutions.

4. *Administration*

(a) *State*

To advise in the formulation of policies for the administration of the medical care program, it is suggested that the State Board of Health establish a Council on Medical Care composed of representatives of all major organizations concerned with the problem.

TABLE 52

THE TOTAL BENEFICIARIES WITH ESTIMATED TOTAL CLINIC CASES, AND THE ESTIMATED TOTAL CLINIC VISITS PER YEAR, ASSUMING AN AVERAGE OF 5.0 CLINIC CALLS PER CASE.

County	Total Beneficiaries	Estimated Total Clinic Cases	Estimated Total Clinic Visits per Year
Calvert	801	97	485
Kent	984	119	595
Charles	1,470	178	890
Talbot	1,540	186	930
Howard	1,544	187	935
Saint Mary's	1,792	217	1,085
Queen Anne's	1,827	221	1,102
Caroline	2,135	258	1,290
Carroll	2,135	258	1,290
Worcester	2,321	281	1,405
Cecil	2,383	288	1,440
Harford	2,845	344	1,720
Montgomery	2,937	356	1,780
Somerset	2,975	360	1,800
Dorchester	3,280	397	1,985
Anne Arundel	3,482	421	2,105
Baltimore	3,770	456	2,280
Prince George's	4,357	527	2,635
Garrett	4,780	579	2,895
Wicomico	4,785	579	2,895
Frederick	6,598	798	3,990
Washington	10,783	1,305	6,525
Allegany	13,202	1,598	7,990
Total	82,726	10,010	50,050

TABLE 53

COST OF CALLS BY GENERAL PRACTITIONERS IN THE OFFICE, HOSPITAL AND THE PATIENT'S HOME, AT $1.50, $1.50 AND $2.50 PER CALL, RESPECTIVELY.

County	General Practitioners			
	Office Calls at $1.50	Hospital* Calls at $1.50	Home Calls at $2.50	Total Cost
Calvert	$ 1,843.50	$ 126.00	$ 927.50	$ 2,897.00
Kent	2,269.50	154.50	1,140.00	3,564.00
Charles	3,385.50	232.50	1,700.00	5,318.00
Talbot	3,547.50	243.00	1,782.50	5,573.00
Howard	3,556.50	243.00	1,787.50	5,587.00
Saint Mary's	4,131.00	283.50	2,072.50	6,487.00
Queen Anne's	4,209.00	288.00	2,115.00	6,612.00
Caroline	4,918.50	337.50	2,470.00	7,726.00
Carroll	4,918.50	337.50	2,470.00	7,726.00
Worcester	5,343.00	366.00	2,685.00	8,394.00
Cecil	5,487.00	376.50	2,757.50	8,621.00
Harford	6,552.00	448.50	3,292.50	10,293.00
Montgomery	6,771.00	463.50	3,402.50	10,637.00
Somerset	6,855.00	469.50	3,442.50	10,767.00
Dorchester	7,555.50	517.50	3,795.00	11,868.00
Anne Arundel	8,025.00	549.00	4,030.00	12,604.00
Baltimore	8,685.00	595.50	4,362.50	13,643.00
Prince George's	10,044.00	688.50	5,042.50	15,775.00
Garrett	11,011.50	754.50	5,530.00	17,296.00
Wicomico	11,020.50	754.50	5,535.00	17,310.00
Frederick	15,202.50	1,041.00	7,637.50	23,881.00
Washington	24,843.00	1,702.50	12,477.50	39,023.00
Allegany	30,414.00	2,083.50	15,277.50	47,775.00
Total	$190,588.50	$ 13,056.00	$ 95,732.50	$299,377.00

*Hospital calls are included in eight counties in which there was no hospital. In these counties a proportion of potential hospital patients is treated in the home, hence these costs have not been deducted.

To administer the program developed by the State Board of Health with the advice of the Council on Medical Care, a Bureau should be established within the State Department of Health. The full-time Chief of this Bureau should be a physician, experienced in the field of medical care, appointed by the Director of the State Department of Health and should serve under his direction.

(b) *County*

In the interests of economy and efficiency, it is suggested that the county health officer, at present the director of the county department of health, should administer the local functions of the program. In the larger counties the health officer would be unable to attend to all details of the program in addition to his usual public health duties, therefore, it would be necessary to employ an assistant to the health officer who need not be a physician.

Medical Social Workers

It is suggested that a medical social worker be employed in each county health department whose duties would include the investigation and classification of all applicants for free medical care. It would be expected that this employee would work in the closest possible cooperation with the county welfare department and that the case records of the latter would be available at all times.

Clerks

In the larger counties it would be necessary to employ additional clerical assistance, while in some of the smaller counties the present personnel might reasonably be expected to do this work along with their usual duties.

County Advisory Council

To act in an advisory capacity to the county health officer in the administration of the local program, it is suggested that a County Council on Medical Care be established which should be composed of one or more representatives of (a) the county medical society (b) the county dental society (c) the county welfare department, (d) the local hospital and (e) the general public.

4. THE COSTS OF OPERATION

It is difficult, if not impossible, to predict accurately the cost of a program for medical care for a given population. In presenting the estimates which follow, it is emphasized that the amounts of fees for service, salaries and other emoluments should not be regarded as an attempt to establish a standard, but merely as an effort to ascertain the probable costs of such a program if it had been in operation during the year 1940.

In the suggested program appropriations for the following services and equipment should be made:

1. *Private Physicians*

   (a) *General Practitioners*

   Fees for office, hospital calls and deliveries, travel for home calls.

   (b) *Surgeons and Anesthetists*

   Payments for service.

   (c) *Clinicians*

   Fees for clinics and travel expenses when necessary.

   (d) *Consultants*

   Payments per consultation and travel, if required.

2. *Hospitals*

   Compensation for all hospital service to eligible persons.

3. *Health Departments*

   Salaries of visiting nurses, dentists and laboratory personnel.

4. *Administration*

   (a) *State*

   Salaries of bureau chief, statistician and clerks.

TABLE 54

THE TOTAL INDIGENT AND THE RESIDENT BIRTH RATE IN THE COUNTIES OF MARYLAND IN 1940, TOGETHER WITH THE ESTIMATED NUMBER OF BIRTHS AND THE TOTAL FEES FOR OBSTETRICAL CARE DURING LABOR, DELIVERY AND THE IMMEDIATE PUERPERIUM AT $25 PER CASE.

County	Total Indigent in 1940	Resident Birth Rate in 1940	Estimated Number of Births	Total Delivery Fees at $25 per Case
Calvert	801	24.4	20	$ 500
Kent	984	19.3	19	475
Charles	1,470	26.3	39	975
Talbot	1,540	18.2	28	700
Howard	1,544	22.1	34	850
Saint Mary's	1,792	26.9	48	1,200
Queen Anne's	1,827	16.8	31	775
Caroline	2,135	19.1	41	1,025
Carroll	2,135	17.7	38	950
Worcester	2,321	17.5	41	1,025
Cecil	2,383	18.6	45	1,125
Harford	2,845	18.7	53	1,325
Montgomery	2,937	20.9	61	1,525
Somerset	2,975	19.0	57	1,425
Dorchester	3,280	17.4	57	1,425
Anne Arundel	3,482	19.4	67	1,675
Baltimore	3,770	19.0	72	1,800
Prince George's	4,357	20.6	90	2,250
Garrett	4,780	24.1	115	2,875
Wicomico	4,785	17.7	85	2,125
Frederick	6,598	17.5	116	2,900
Washington	10,783	18.5	199	4,975
Allegany	13,202	20.1	265	6,625
Total	82,726	19.6	1,621	$40,525

(b) *County*

Salaries of health officers, assistants, medical social workers and clerks.

General clinic equipment, supplies, drugs and biologicals.

Dental laboratory, X-ray and other special equipment.

Remodeling and rentals.

1. *Private Practitioners*

(a) *General Practitioners*

(i) *Fees for office, hospital and home calls*

In Table 53, page 64, the fees of general practitioners for office, hospital and home calls have been calculated by counties in accordance with the following scale: office calls, $1.50; hospital calls, $1.50; and home calls, $2.50. The total estimated cost for these services is $299,377 of which $190,588.50, $13,056.00 and $93,732.50, are the costs for office, hospital and home calls, respectively.

(ii) *Fees for deliveries*

In 1940 in the counties of Maryland the resident birth rate was 19.6 per 1,000 population. Among 82,726 individuals, therefore, there would have been approximately 1,621 births. The theoretical distribution of births by counties is shown in Table 54, page 65. If the fee for complete care during labor, delivery and the immediate puerperium were $25, the total payments for 1,621 births would be $40,525. The estimated costs by counties are included in the same Table. Calls for obstetrical care, other than those for labor, delivery and the immediate puerperium, have been included in the office, hospital, and home visits.

(iii) *Travel for home calls*

For 43,514 attended cases it has been calculated that there would be 6,112 home calls. Of the latter it is estimated that 3,056, or 50 percent, would be distributed within a radius of less than 3 miles from the physician's residence; 1,834, or 30 percent, from 3 to 5 miles; and 1,222, or 20 percent, over 5 miles.

For services requiring travel in excess of 3 miles, but not more than 5 (one way) from the physician's residence, $2.50 is used as the travel allowance in addition to the usual fee, and $5 for distances in excess of 5 miles.

For 1,834 calls, at $2.50 per call, the payments for travel would be $4,585; for 1,222 calls, at $5, they would amount to $6,110. The total estimated travel costs for general practitioners, therefore, is $10,695.

[1]Collins, Selwyn D.: Frequency and Volume of Hospital Care for Specific Diseases in Relation to all Illness Among 9,000 Families, Based on Nation-wide Periodic Canvasses, 1928-31, Pub. Health Rep., 57:1399-1428 (Sept. 18, 1942) and 57:1439-1460 (Sept. 25, 1942) Reprint No. 2405.

(b) *Surgeons' and Anesthetists' Fees*

Since physicians would be paid for the care of indigent patients, it seems reasonable and proper that surgeons also should be compensated for their services.

Of all hospital cases, it has been estimated[1] that 62 percent were surgical and 38 percent non-surgical patients. Since it is estimated that there would have been 5,095 hospital cases in 82,726 persons, the surgical patients would total 3,090 cases. Five specific conditions were listed as extremely frequent in hospital practice, namely, tonsillectomies, deliveries, accidental injuries, acute appendicitis and female genital diseases.

If 75 percent of the 3,090 surgical cases, or 2,318 patients, were operated upon, and if the average fee for major and minor surgery were placed at $25, the total payments would be $57,950.

At an estimated fee of $10 per operation for anesthetists, the payments would total $23,180.

(c) *Clinicians*

It is suggested that clinicians be compensated on a fee per clinic basis, with travel allowance when necessary. A fee of $10 is used in the calculations with an average travel allowance of $20 per clinic. The latter involves inter-county travel and is a rate somewhat less than that of the Maryland Tuberculosis Association, which however, uses fewer clinicians covering the same area with a resultant higher average distance per clinician.

Five types of clinics in addition to those now being conducted in each county are believed to be necessary—

TABLE 55

THE TOTAL CLINICS PER YEAR IN EACH COUNTY AND IN EACH GROUP OF COUNTIES,* WITH TOTAL CLINICIANS FEES AT $10 PER CLINIC AND TRAVEL AT $20 PER CLINIC.

County Group*	Total Clinics Per Year		Clinicians Payments		
	In Each County	In Each Group	Fees at $10	Travel at $20	Total
I (11 counties)	60	660	$6,600	$13,200	$19,800
II (9 counties)	120	1,080	10,800	21,600	34,400
III (3 counties)	240	720	7,200	**	7,200
Total	—	2,460	$24,600	$34,800	$59,400

*Group I—Calvert, Kent, Charles, Talbot, Howard, St. Mary's, Queen Anne's, Caroline, Carroll, Worcester and Cecil counties.
Group II—Harford, Montgomery, Somerset, Dorchester, Anne Arundel, Baltimore, Prince George's, Garrett and Wicomico counties.
Group III—Frederick, Washington and Allegany counties.
**Travel allowances are not included for these counties, since it is assumed that clinicians would be available locally.

Internal Medicine, Surgery, Obstetrics and Gynecology, Pediatrics and Ophthalmology and Otolaryngology—the frequency varying from one to four of each per month, depending upon the estimated total indigent in the county. The total costs are summarized in Table 55, page 66.

For all of the five types of clinics in all counties, there would be 2,460 clinics per year, while the total estimated cost of this service is $59,400, which includes $24,600 for clinicians' services and $34,800 for travel.

(d) *Consultants*

For all counties, it is felt that there should be a minimum of 10 consultants; 2 each in internal medicine, surgery, obstetrics and gynecology, pediatrics, and ophthalmology and otolaryngology.

As a basis for estimating the total cost, a consultation fee of $10 has been used with an average travel allowance of $20. The latter is based on the assumption that the majority of the consultants would reside in Baltimore City and that inter-county travel would be involved.

For 43,514 attended cases it is estimated that 435, or 1 percent, would require consultants' services in addition to those which would be available in the clinics. The cost, therefore, for fees would approximate $4,350 while the travel payments would amount to about $8,700, or a total cost of $13,050.

2. *Hospitals*

In all counties a total of 152,111 free hospital days was reported by 16 general hospitals which received allocations totalling $219,038 from State and local governments in 1939-40, or an average of $1.82 per free hospital day. In these hospitals the average cost was reported to be $3.80 per hospital day. In order to compensate the hospitals adequately, therefore, the allocations should be increased from $219,038 to $457,332, or by about 109 percent. Of the former amount the State of Maryland contributed $162,000, or 72.9 percent. The augmented State allocation, therefore, should approximate $337,968, or $175,968 in new funds. At the same time the local government appropriations should be increased from $57,038 to $119,363 in order to attain the total from all sources of $457,332.

In 1940, 7,296 county patients were treated in hospitals in Baltimore City for a total of 76,235 hospital days. These hospitals were allocated $221,000 by the State of Maryland for care of free patients of which the county residents comprised about 25 percent. At $3.80 per hospital day, the estimated cost, the Baltimore hospitals would have received $289,693. Of the State allocation of $221,000, it is estimated that approximately $55,250 was expended for county residents. It is clear, therefore, that in order to compensate the hospitals in Baltimore City for hospitalization of free county cases a total of $231,443 should be added to the allocation of the State of Maryland.

Future State Appropriations for Hospitalization

It has been indicated that current methods for allocating State funds for general hospitals are unsatisfactory in several important respects. In order to establish a more equitable distribution, and concurrently with any increase in appropriations, it is suggested that the following steps be taken:

1. A "free hospital day" should be clearly defined and a basis of payment for it be established.
2. A medical social worker, attached to the staff of the county health department, should determine the eligibility of applicants for free hospitalization.
3. Hospitals should be licensed by the State Board of Health, after conforming with minimum standards which should be established by that Board, and these should include (a) the installation of a uniform system of accounting, (b) the maintenance of appropriate professional standards, and (c) periodic inspections to determine the extent to which licensing standards are maintained.

3. *Health Departments*

(a) *Visiting Nurses*

As a basis for estimating the cost of visiting nurses service, the minimum salary has been placed at $1,500 with a travel allowance of $600 per year. These rates are in accordance with the current standards for public health nurses.

The suggested distribution of visiting nurses, in accordance with the estimated number of indigent in 1940, and the costs are found in Table 56, on page 67.

TABLE 56

THE NUMBER OF NURSES SUGGESTED FOR EACH COUNTY AND IN EACH GROUP OF COUNTIES, TOGETHER WITH ESTIMATES OF THE COSTS.

County Group	Number of Nurses		Salaries and Travel per Year		
	In Each County	In Each Group	Salaries at $1,500	Travel at $600	Total
I (11 counties)	2	22	$33,000	$13,200	$46,200
II (9 counties)	3	27	40,500	16,200	56,700
III (3 counties)	4	12	18,000	7,200	25,200
Total	—	61	$91,500	$36,600	$128,100

(b) *Dentists*

The number of dentists recommended for each county and the travel allowances are shown in the Table below. It will be observed that a minimum annual salary of $3,000 has been suggested, with a travel allowance of $600 per year.

TABLE 57

THE NUMBER OF DENTISTS SUGGESTED FOR EACH COUNTY AND EACH GROUP OF COUNTIES, TOGETHER WITH THE SALARIES AND TRAVEL.

County Group	Number of Dentists		Salaries and Travel Per Year		
	In Each County	In Each Group	Salaries at $3,000	Travel at $600	Total
I (11 counties)	1	11	$33,000	$ 6,600	$39,600
II (9 counties)	1	9	27,000	5,400	32,400
III (3 counties)	2	6	18,000	3,600	21,600
Total	—	26	$78,000	$15,600	$93,600

It will be observed that for 26 dentists the sum of $78,000 is allocated for salaries and $15,600 for travel allowances, a total of $93,600. From this amount, however, should be deducted the sum of $19,801 which was the amount expended in 1940, giving a final estimate of $73,779 for augmented dental services.

(c) *Clinical Laboratory Personnel*

It is estimated that a minimum of 12 additional bacteriologists would be needed—3 in the central laboratory in Baltimore and one in each of the 9 branch laboratories.

The salaries are estimated on a basis of an average of $1,800 per year or a total of $21,600.

4. *Administration*

(a) *State*

The following minimum salaries and expenses should be provided for the proposed Bureau of Medical Care of the State Department of Health:

Chief of Bureau, Salary	$ 5,000
Travel	1,200
Statistician	2,500
Clerks, three	5,500
Office expenses	2,500
Total	$16,700

It is assumed that the Bureau of Personnel and Accounts of the State Department of Health would accept responsibility for such functions of the Bureau of Medical Care as the payment of accounts, which the former is now performing for other Bureaus of the State Department.

(b) *Counties*

(i) *The County Health Officers*

Since administration of the medical care program by health officers would impose additional responsibilities upon them, it seems both appropriate and necessary that the salaries of health officers should be increased. The amounts suggested are set forth in the following Table:

TABLE 58

THE NUMBER OF COUNTY HEALTH OFFICERS WITH SUGGESTED MINIMUM INCREASES IN SALARY FOR ADMINISTERING THE PROGRAM OF MEDICAL CARE

County Group	Number of Officers		Salary Increases Per Year	
	In Each County	In Each Group	Salaries Increases	Total Increases
I (11 counties)	1	11	$ 500	$5,500
II (9 counties)	1	9	750	6,750
III (3 counties)	1	3	1,000	3,000
Total	—	23	—	$15,250

It is suggested that assistants to the county health officers be provided in Frederick, Washington and Allegany counties at an annual salary of $2,400 or a total cost of $7,200.

(ii) *Medical Social Workers*

If one worker in each county received an average salary of $1,800 per annum with a travel allowance of $600, the cost of medical social service workers' salaries would total $41,400 and the travel $13,800. A total expenditure of $55,200 would be involved.

(iii) *Clerks*

With one additional clerk in each of the 20 county health departments in Groups I and II at an average salary of $1,200, the total salaries would be $24,000. For two clerks in each county in Group III, the salaries would amount to $7,200. The total expenditures for clerical assistance would be $31,200.

(iv) *Clinical Equipment, Supplies, Drugs and Biologicals*

The minimum clinical equipment, supplies, drugs and biologicals with estimated costs have been tabulated below:

EQUIPMENT	ESTIMATED COST
Examination tables	$ 50
Cabinets and shelves	75
Instruments	200
Desks, tables and chairs	150
Filing cabinet	50
Miscellaneous	75
Total	$ 600

SUPPLIES	ESTIMATED COST
Stationery	$ 50
Linens	75
Dressings and bandages	50
Miscellaneous	75
Total	$ 250

DRUGS AND BIOLOGICALS	ESTIMATED COST
Prescriptions (local pharmacists)	$ 500
Emergency drugs (clinics)	250
Emergency biologicals (clinic)	250
Total	$1,000

Cost of the above minimum equipment, supplies, drugs and biologicals totals $1,850. For larger counties additional amounts should be provided in accordance with the scale in the following Table.

TABLE 59

THE ESTIMATED COST OF EQUIPMENT, SUPPLIES, DRUGS AND BIOLOGICALS

County Group	Cost of Equipment, Supplies	
	In Each County	In Each Group
I (11 counties)	$ 1,850	$20,350
II (9 counties)	2,550	22,950
III (3 counties)	3,250	9,750
Total	—	$53,050

(v) *Special Equipment*

(i) *Dental*

With one dentist in each of the 20 counties in Groups I and II, the estimated cost of equipment and supplies is $800 per county, or $16,000 in all. With two dentists in the remaining 3 counties, it is estimated that the cost of equipment and supplies would be $1,600 in each county, or a total of $4,800. For all counties the costs of dental equipment and supplies would total $20,800.

(ii) *Laboratory*

For additional equipment and supplies for clinical laboratories operating in conjunction with existing bacteriological laborarories of the State Department of Health, it is suggested that a total of $15,200 should be appropriated.

(iii) *X-ray*

It is suggested that provisions be made for the installation of X-ray and other special diagnostic facilities in the county health departments for which the initial amount of $15,000 should be allocated.

(c) *Remodelling and Rentals*

In most county health departments it would be necessary to remodel, make additions to present quarters, or to rent more space.

It has been estimated that the following costs would be involved:

Remodelling	$7,500
Rentals	1,400

It is known that in a number of county health departments additional rooms could be obtained without cost, since they are located in public buildings.

SUMMARY OF ESTIMATED ANNUAL COSTS OF MEDICAL CARE PROGRAM FOR 82,726 INDIVIDUALS IN THE COUNTIES OF MARYLAND

	Total Expenditures		Percent of Total
1. SERVICES OF PRIVATE PHYSICIANS			
(a) GENERAL PRACTITIONERS			
Office Calls	$190,588		
Hospital Visits	13,056		
Home Visits	95,733		
Deliveries	40,525		
Travel for Home Visits	10,695	$350,597	
(b) SURGEONS AND ANESTHETISTS			
Surgical Services	57,950		
Anesthetists Services	23,180	$ 81,130	
(c) CLINICIANS			
Clinic Fees	24,600		
Travel	34,800	$ 59,400	
(d) CONSULTANTS			
Consultations	4,350		
Travel	8,700	$ 13,050	
		$504,177	36.7
2. HOSPITALIZATION			
Increased payments to Hospitals in Counties	175,968		
Hospitalization of County Residents in Baltimore City in Addition to Current Expenditures	231,443	$407,411	29.7
3. HEALTH DEPARTMENT SERVICES			
Visiting Nurses, Salaries	$ 91,500		
Visiting Nurses, Travel	36,600		
Dentists, Salaries	78,000		
Dentists, Travel	15,600		
Clinical Laboratory Personnel	21,600		
	$243,300		
Less Dental Appropriations (1940)	19,801	$223,499	16.3
4. ADMINISTRATION			
(a) State Office	16,700		
(b) County Offices:			
County Health Officers, Part Salaries	15,250		
Administrative Assistants	7,200		
Medical Social Workers, Salaries	41,400		
Medical Social Workers, Travel	13,800		
Clerks, Salaries	31,200	$125,550	9.1
5. EQUIPMENT			
Equipment, Supplies, Drugs and Biologicals	53,050		
Dental Equipment and Supplies	20,800		
Laboratory Equipment	15,200		
X-ray and other Special Equipment	15,000		
Remodelling and Rentals	8,900	$112,950	8.2
		$238,500	
Total		$1,373,587	100.0

Chapter X

ACTIVITIES OF THE EXECUTIVE COMMITTEE

Special Inquiries

QUITE APART FROM THE FIELD SURVEY of the counties of Maryland, the Executive Committee of the Committee on Medical Care conducted a series of special inquiries on a number of related subjects including:

1. Medical Care Problems in the Counties and Their Relationship to Medical and Hospital Facilities in the City of Baltimore.
2. Facilities for the Treatment of Chronic Disease.
3. The Need for a Central Hospital Admitting Service.
4. The Integration of Independent State Agencies Providing Medical Care.
5. The Outpatient Medical Services in the City of Baltimore.

1. *Medical Care Problems in the Counties and Their Relationship to Medical and Hospital Facilities in the City of Baltimore*

From the beginning, the Committee has considered that its function is State-wide. Indeed, from a practical point of view, it is impossible to separate medical care in Baltimore from medical care in the counties. Medical facilities in Baltimore are a part of the whole State's equipment for medical care and are so used, as has been clearly shown in Chapter VI. A study of medical care in the counties of Maryland would be only partially completed if this relationship to the medical facilities of Baltimore were not considered.

Many of the economic difficulties which arise in providing medical care for county residents relate to the cost of hospitalization in the city. Similarly, it is not possible to obtain an adequate view of the problems of Baltimore's medical institutions and facilities without considering their use by county residents. This is particularly true of counties immediately surrounding the City, but to some extent applies to the whole State.

The size of Baltimore and the multiplicity of the voluntary, city, State and private institutions furnishing medical care are such as to demand most careful study before suggestions can be made for the more effective use of these facilities.

As in the counties, certain data are obtainable. These relate chiefly to medical services which are already well performed. The interest of the Committee, however, is concerned chiefly with those medical needs which at present are less well met. Before a sound opinion can be formed as to the practicability of any remedial plan, it will be necessary to obtain quantitative data on many of these unmet needs—the necessary personnel, the costs, and the essential type of administration.

Among the obvious unmet medical needs in Baltimore are some which are State-wide in character. For example, there is need for a solution of the problem of the care of the defective and delinquent child. This problem should certainly not be approached on either a county or a city basis, but as a State-wide problem demanding a State-wide solution. The State has long determined that mental defectives are a State problem whether they occur in the city or in the county. Similarly, the study of tuberculosis can not be approached without knowledge of both City and county needs. On the other hand, there are very important unmet medical needs in Baltimore which have a distinctly local character, and they must be solved locally. These, however, are problems of such magnitude that the Committee feels that they should be the subject of a separate inquiry and report.

2. *Facilities for the Treatment of Chronic Disease*

(a) *Evidence of Need*

Chronic disease is increasing in frequency as the average age of the population tends to advance. Maryland, with respect to meeting the need for medical care for the chronic patient, has not yet solved the problem.

In Baltimore City, it is true, there has been a fairly rapid expansion of the size of the chronic hospital which is a part of the group of City Hospitals. In spite of this expansion there usually exists a waiting list of approximately 500 cases. The problem is an especially serious one since the City has at present no method of providing home care for those chronically ill patients for whom hospital beds are not available.

In the counties of Maryland hardly a beginning has been made in the provision of hospital beds for chronic cases. In fifteen counties almshouses, or "county homes", still exist. In 1939, when a study of these institutions was made by the State Department of Public Welfare at the request of the Legislative Council, it was found that 556 individuals resided in the almshouses. Of this number, 319 were found to be handicapped physically or mentally to such a degree that they required chronic hospital care. It was clearly demonstrated that the almshouses contained many patients for whose care the necessary facilities were not available.

(b) *The Kind of Care Needed*

Certain facts must be considered in connection with the development of a State-wide program for the chronically disabled patient. The kind of care that is needed in an individual case depends not so much upon the nature of the chronic disease, as upon the character and degree of mental and physical disability which has resulted from it.

All estimates of the number of patients needing chronic hospital care are untrustworthy—if they are based upon medical diagnoses, such as arthritis, arteriosclerosis, heart disease and the like. Patients with any of these conditions may come in one of the following categories: (i) those capable of self-support, (ii) those disabled to the extent that they need boarding-home care with occasional medical supervision, (iii) those sufficiently handicapped to require infirmary care with nursing attendance and regular medical supervision, or (iv) those who are bedridden and require chronic hospital care. During any of these stages these patients may have acute exacerbations or complications, placing them in group (v) those who require the type of medical care which can be given only in a general hospital. These types of service, namely, boarding-home, infirmary and chronic and general hospital care, increase in cost in the order named.

A program for the care of the chronically ill should include provision for each category of care, and it is equally important that facilities should be provided for classifying the patients. Moreover, it is characteristic of most of the chronic diseases that the condition is progressive, so that an adequate system must include provision for the ready transfer of a patient from one class of care to another as his condition requires. Many older patients will do well in the infirmary section in summer, but in winter may have to be transferred into the chronic hospital. Similarly, the chronic hospital cases will develop such complications as urinary retention, pneumonia and coronary thrombosis, which would make it necessary to transfer them at once to a general hospital. On the other hand, patients at the end of a long, acute illness in the general hospital, may be permanently disabled and have to be transferred to the chronic hospital. This relationship makes it highly desirable that the infirmary, the chronic hospital and the general hospital be not far separated. If the chronic hospital is built near a general hospital, not only will these transfers be facilitated, but the medical services in the chronic hospital will be strengthened by the availability of professional consultant services from the general hospital. It would also be unnecessary to install in the chronic hospital those expensive medical facilities which would be absolutely necessary if a general hospital was not within easy reach.

(c) *Results to be Expected*

Though a large proportion of the cases admitted to infirmaries and chronic hospitals are incurable, there will be a definite percentage in which this will not be so. The chronic hospital will give a chance for life and for more or less complete recovery to many patients who, because of the great length of their illness, can seldom receive treatment over a sufficient length of time in the general hospitals. Many cases of arthritis fall into this group, and this disease is one of the leading causes of chronic total disability. Arthritis requires prolonged, persistent treatment, which is generally unobtainable in the general hospital or in the home. With adequate care the ultimate results are usually far less disabling in character. Certain types of paralyses are likewise susceptible to great improvement in function if skilled care and nursing can be given for a sufficient length of time.

It seems evident that great advantages would be gained if this complex system, comprising many varieties of medical care, were placed under unified direction. In order to function efficiently, it can not be administered in sections.

(d) *Provisions for Expansion*

The present magnitude of this problem cannot be determined. Only an extensive survey of the whole State, with classification of disabled individuals according to the type of care that they need, would produce really valuable estimates. On the other hand, such data as have been obtained seem to indicate that it is probably neither possible nor wise to attempt a complete solution of the problem in one step. Provision should certainly be made, however, in the selection of sites and in the architectural plans, for the construction of additions to the chronic hospitals and infirmaries, as the need for them is established.

3. *The Need for a Central Hospital Admitting Service*

There are a number of steps which are of necessity involved in the admission of a patient as a free case to a ward in one of the Baltimore hospitals. The first is the examination of the individual, which determines that his hospitalization is necessary. The second is the investigation which shows that his economic status is such that, without assistance, he can not pay for hospital care. Finally, a hospital must be found which will receive him.

The first task is obviously that of a physician except in accidents or other emergencies, in which the need for hospitalization is evident. The task of determining the economic status is that of the department of welfare or of the hospital. This determination would precede admission if the patient's condition permitted, otherwise it would follow. The third task, that of finding an institution that will admit the patient, is the duty of no specific person. It becomes, therefore, the task of whomever has the problem

on his hands, whether it be a physician, a nurse or an ambulance driver. For example, a patient enters the accident room of a hospital, is obviously ill and requires immediate hospitalization. The interne who examines him finds that there are no vacant beds in the institution. It devolves upon him, or upon the nurse who assists him, to find a bed elsewhere for this patient. This must be done by calling the admitting office of other institutions in the city until one has agreed to take the patient. An ambulance is then called to transport the patient to that hospital. If, as sometimes happens, the interne is unable to hospitalize the patient, some way must be found to care for the patient at his home. If the patient resides in one of the counties, he must be returned to it.

There are obvious disadvantages in this procedure. The interne is inexperienced in this type of work, not well acquainted with the resources of the city, and harassed in the performance of this duty by the demands of other cases needing his attention. The method is inefficient in a second particular in that failures to secure hospital accommodations are not recorded at a central office, so that unmet medical needs are not brought to the public attention.

In the winter of 1939-1940, for example, when there was a high incidence of pneumonia among children, the number of hospital beds available for children was insufficient. A considerable number of children had to be treated in the home under the supervision of a dispensary physician. This unmet need, however, was not disclosed until a specific inquiry by this Committee brought it to light.

It has already been pointed out in Chapters VII and VIII that in attempting to hospitalize indigent persons in Baltimore, county health and county welfare departments reported that it was frequently necessary to make four or five long distance calls to various hospitals before a hospital could be found which would accept the patient.

It would seem that some agency should be provided with facilities for and charged with the responsibility of finding a bed for any indigent case whose need of hospitalization has been certified by a physician. A central admitting office would accomplish this task far more efficiently than a physician or nurse. Moreover, there would be accumulated in a very few years a record of the unmet needs for hospital care which would offer a much sounder basis for future hospital development than we now possess.

4. *Integration of Independent State Agencies Providing Medical Care*

The Executive Committee devoted several sessions to the study of the organization chart of the State Government. It was observed that a number of State agencies were concerned with various aspects of the problem of medical care. For example, many departments maintained services for the physical examination of their employees or candidates for employment, each with varying standards. Furthermore, it was noted that the administration of hospitals and other institutions having to do with medical care presented a complex picture. For example, overcrowding of institutions for care of psychotic patients was reported, and a need for additional beds for patients suffering from tuberculosis was indicated.

In the interest of promoting economy and efficiency, the Committee suggested that the many agencies concerned should be integrated. It was also agreed that the manner in which they might be combined to effect the greatest economy should be the subject of further investigation.

5. *The Outpatient Medical Services in the City of Baltimore*
(a) *The Problem Defined*

No extensive study of the outpatient facilities of Baltimore has as yet been possible, but certain problems relating to them have been discussed at meetings of the Executive Committee, and their nature is outlined in order to emphasize the need of further study.

A primary problem is the relative dissociation of the medical care given in an outpatient department from that received by the same patient in his home, in physicians' offices, in other outpatient departments or in hospitals. The outpatient physician has no contact with the patients' home environment, or with the manifestations of illness he has suffered there, or the treatment given for it. If the patient is admitted to a hospital the outpatient physician rarely has an opportunity to follow the patient's illness on the wards, and often after discharge from a hospital the patient does not return to the same outpatient physician. As a result, the typical outpatient has many physicians rather than one, and it is natural that he is often treated as a case of disease rather than as an individual whose disability may be due in part to other types of strain than the disease from which he is suffering. This handicap of the outpatient type of medical care seriously impairs its efficiency.

Obstetrical departments have found it possible to offer a service combining home, outpatient and hospital care. The possibilities of organizing similar combined services in other branches of clinical medicine should be thoroughly explored.

The outpatient departments in Baltimore vary greatly as to the completeness of the medical service which they are able to offer to their patients. Faithful attendance and interest on the part of the outpatient physicians influence greatly the number of patients visiting a clinic. A factor of even greater importance appears to be the prestige of the institution and the variety of departments and of

facilities which it contains. The tendency to seek treatment in the larger clinics associated with the Johns Hopkins and the University of Maryland medical schools is overloading these clinics, while attendance in the smaller outpatient departments tends to remain stationary or even to diminish. The smaller institutions are similarly handicapped in attempting to provide medical personnel for outpatient service since they have no funds for this purpose, and the work has little attraction for the physician from an educational standpoint. The patient is usually right in assuming that in these institutions he will, if necessary, receive the most expert attention, but he is often wrong in believing that his particular condition requires more than can be well supplied by the smaller outpatient department near his home.

Only more careful consideration than has been possible can determine whether it is wiser to encourage the closing of some of the smaller clinics or whether it would be feasible to limit the intake of the larger clinics to those needing intensive study, referred by the less well-equipped clinics, or by private physicians.

(b) *Financing Outpatient Departments*

The financing of outpatient departments offers increasing difficulties to the institutions to which they are attached. In most instances the costs are not available, but in the larger institutions here and in other cities, they have been found to approximate $1.00 to $1.50 per patient visit, exclusive of professional service which is donated by the physician. In order to finance the heavy cost of their outpatient departments, the larger clinics have been forced to charge fees to patients who can pay. The remainder of the upkeep must be provided from general hospital funds. Thus the desire of the hospitals to maintain their charitable work often results in their using some of the income from pay patients for service for free and part-pay patients.

The financial problem thus briefly outlined is not a simple one, but surely it deserves further study in the hope that some more equitable way of meeting outpatient costs can be found.

In the opinion of the Committee, the principle should be adopted that the deficits incurred by non-profit medical institutions in giving medical care to free and part-pay patients should be met either by voluntary philanthropy, or from taxes upon the whole community, but adverse balances should not be met even in part by increased charges to the pay patients.

The amount of money available from philanthropy which is available for the support of outpatient departments, or of hospitals generally, will vary according to the wealth of the community. It is of interest, however, that even throughout the depression years, certain cities found it possible to pay these deficits from their Community Funds. In Cleveland, for example, the voluntary hospitals running dispensaries, classified all individuals on admission as free, part-pay, or full-pay patients. The part-pay patients paid various fractions of the cost, according to their income and responsibilities. The full-pay patients paid full cost, but nothing in excess of cost. A bill was rendered to the Community Fund for the deficit incurred in caring for the free and part-pay patients.

In other cities a large proportion of the outpatient work is carried on in city dispensaries, in which the entire cost is supplied from tax funds. Occasional communities appropriate from the tax funds to assist in financing voluntary outpatient services. In Baltimore the bulk of the outpatient work which is done by the medical institutions of this city, is not supported by either philanthropy or tax funds. Moreover, the City of Baltimore does not conduct any large outpatient service in connection with the City Hospitals, and the amount of definitive medical care provided by the dispensaries maintained by the Baltimore City Department of Public Welfare is a small part of the whole.

It should be pointed out that in any true estimate of the cost of outpatient medical care, approximately one-half would be the value of the services now donated free of cost by the physicians staffing these clinics. The community has become so accustomed to accepting the medical profession's disproportionate burden in the medical care of the indigent, that there is danger that it may assume, without justification, that these free services will always be available in sufficient amount to meet the needs. Changing conditions, however, render it doubtful whether such an assumption is justified.

A physician gives his time to an outpatient department partly, it is true, for purely philanthropic reasons, and because it is in the tradition of his profession, but also because he is influenced to a very considerable extent by the educational value to himself offered by this opportunity to study disease.

The value of this educational opportunity in many clinics is steadily diminishing for a variety of reasons. Adequate study of a patient today is a far more complex process than it was a few decades ago. It requires more extensive laboratory studies, more X-ray investigation, more specialized types of diagnostic and therapeutic equipment. Many of the clinics, ill-supported as they are, are unable to supply these facilities. A physician is then apt to feel that he is doing no more advanced work than he could do in his own office, and to conclude that as far as his philanthropy goes, it will still have extensive application among the free patients in his private practice, and that he gains nothing by continuing his association with the outpatient clinic. This is one reason why outpatient clinics are finding it increasingly difficult to staff their departments with an adequate number of physicians.

Another difficulty in maintaining outpatient clinics is that when overcrowding of a clinic occurs the patients have to be pushed through at such a rate of speed that careful work, the *only* type that has educational value, is quite impossible. The physician leaves the clinic often late to keep his own appointments, with the sense of dissatisfaction that goes with a hastily done task.

(c) *Physical Examination of Applicants for Relief*

To complicate the picture still further, in recent years there has been thrust upon outpatient departments by the relief agencies, the task of determining the employability of relief workers. That such examinations must be made is not questioned, but they certainly should be performed in places other than in outpatient departments. Those examinations seldom provide any real interest to the dispensary physician, and interest in his work is the chief stimulus which impels him to continue to serve in an outpatient department.

(d) *Conclusion*

Many of those who have studied these problems feel that if the State and the community persist in being pennywise in furnishing support to the outpatient departments, they may awake to find that, through the need of having to pay physicians to staff these institutions, they have been pound foolish.

If, in the discussion of certain aspects of our outpatient system in Baltimore, stress has been chiefly laid upon the problems which afflict them, and in some instances threaten their existence, it is because the chief purpose of the Committee's existence is to point out deficiencies, and to suggest remedies. Yet the discussion should not be discontinued without drawing attention to the tremendous value to the community of the outpatient system as a whole, and to the vast amount of medical care it furnishes to the indigent and medically indigent of Baltimore, its environs, and indeed to the State as a whole. Approximately half a million visits a year are paid to these institutions. A very high quality of care is given. Any threat to their existence or continuing service is of grave concern to all citizens of Maryland.

Summary

1. It was found that several medical care problems in the counties and in the City of Baltimore are inextricably interwoven, particularly those which have to do with hospitalization, the care of defective and delinquent children, mental defectives and tuberculosis, while some other problems have a distinctly local character and must be solved locally.

2. The problem of the treatment of chronic disease has been discussed, and the urgency of the need for construction of hospital centers has been stressed. For medical and economic reasons it is suggested that patients be classified according to the type of care they require, and that provisions be made for treatment in the boarding home, infirmary, chronic hospital and general hospital, and that prompt transfer from one facility to another be made possible, as the condition of the patient indicates. It is urged that such facilities be localized, and that they be placed under unified direction. Until the magnitude of the problem is fully determined it is suggested that one or two such hospital centers be erected with ample provisions for expansion.

3. The several steps necessary at present for securing admission of free cases to hospitals in the City of Baltimore were detailed, procedures involving loss of time on the part of physicians, nurses and others. County health and welfare departments both have reported that it was not unusual to make several long distance calls before a hospital bed could be secured.

From the foregoing it is apparent that there is a need for a central admitting service, the creation of which should be one of the earliest concerns of the Council on Medical Care.

4. In the interests of economy and efficiency it is suggested that efforts should be made to integrate the many State agencies now concerned with various phases of medical care. The organizations involved and the manner in which they should be combined are suggested as topics for further investigation.

5. Problems related to outpatient facilities of Baltimore City include consideration of (a) the relative dissociation of the medical care given in an outpatient department from that received by the same patient in the home, in physicians' offices, and in the outpatient departments of other hospitals, (b) the type and quality of medical services offered by the different clinics, (c) the source of payment for the service rendered; (in the opinion of the Committee deficits should not be met, even in part, by increased charges to pay patients. About one-half of the value of services rendered is donated by clinicians, a disproportionate share). In many departments the value of the educational opportunity to clinicians is steadily diminishing for a variety of reasons—one of which is that of routine examinations of applicants for relief.

The outpatient departments in hospitals in Baltimore furnish more than 500,000 visits a year to indigent and medically indigent patients in Baltimore, its environs, and to a lesser degree in every county in the State. Any threat to their existence is of grave concern to all citizens of Maryland.

Chapter XI

FURTHER ACTIVITIES OF THE EXECUTIVE COMMITTEE

Introduction

In many of its sessions the subject of medical care in rural areas has engaged the attention of the Executive Committee of the Committee on Medical Care and physicians, dentists, county health officers and public welfare officials from rural districts were interviewed. Furthermore, as the field study progressed, the findings were reviewed and discussed.

The efforts of the Committee were by no means confined to making studies of existing medical care agencies and to forming estimates of the costs of such improvements as are obviously necessary. Much of the time of this Committee and much of its resources were devoted to arranging conferences aimed to establish better integration of the work of existing agencies in this field. In particular, a solution was sought of the fundamental problem—*that of determining the most desirable method of administering the portion of the field of medical care which is partly or completely tax-supported.* At present both in the City of Baltimore and in the counties neither the professional societies, the voluntary health and welfare associations, the departments of health nor the departments of public welfare have any authorization or responsibility for developing or administering a unified program of medical care. Among all those concerned it was vital, therefore, to obtain agreement as to the type of administrative control which is to be recommended to the legislative bodies of the State.

The individual members of the Committee have had many years intimate contact with the various aspects of this problem. Furthermore, in several instances, they have played a part in medical relief programs in this State and elsewhere. As a result of these experiences and the discussions and other activities of the Executive Committee, its members have come to hold definite opinions as to the essentials which should be embodied in a program for medical care in the counties of Maryland.

The Nature of the Problem of Medical Care in the Counties

The term "medical care" signifies the total preventive, diagnostic and curative medical services furnished the population in their homes, in physicians' and dentists' offices, in clinics and in general and special hospitals.

The subject of medical care has received an increasing amount of nation-wide attention in recent years. With the expenditure of vast sums of money for relief by Federal, State and local governments, medical care has come to be acknowledged as an integral part of the problem of maintaining, at public expense, those who lack financial means to support themselves.

Moreover, for several decades the medical profession, those interested in social welfare, and the general public, have realized that modern developments of scientific medicine have so increased the cost of medical care that many of those financially able to provide themselves with other necessities are often unable to meet the monetary demands incident to serious illness or prolonged physical disability.

Studies of the provisions for medical care for the indigent have demonstrated to the Committee on Medical Care that in many areas such medical services are, in general, restricted to bare emergency services, and that these deficiencies constitute a serious and urgent problem, particularly when it is clear that the lack of medical care and rehabilitation is frequently the basic cause of indigency.

The nature of the problem varies in different areas, but some of its characteristics may be summarized as follows:

1. The number of physicians in a rural area depends in part upon the number of people able to pay a physician. In an impoverished area, therefore, with a large number of people dependent on free care, there are few physicians available. The distribution of physicians should be in proportion to the population. Instead, it is in inverse proportion to it if poverty is general. This situation will grow worse instead of better unless a solution can be found.

2. Public funds for home, hospital and clinic care are inadequate in practically all counties. In the counties in the lower economic level, the amount of medical work which must be done without compensation is quite beyond the possible load for the number of available physicians and hence only emergency care can be given.

3. Facilities such as consultant services, adequately equipped hospitals and clinical laboratories, dental and nursing services, were lacking in a number of areas, and the level of medical care available to the entire population suffered accordingly.

4. The activities of the State and county departments of health in providing special clinics for certain types of disease have been very helpful, but they cannot be regarded as even a partial solution of the medical care problem. A great volume of acute and chronic

disease cannot be cared for by these special clinics nor was that the purpose for which they were established. The State and county health departments, however, aid the practicing physician by furnishing certain types of laboratory and X-ray service, drugs for the treatment of venereal disease and a variety of preventive and therapeutic biologicals. Within their legislative and budgetary limits, the State and County departments of welfare also played an important part in the medical care program as it existed in the counties when the field survey was made.

5. There is no governmental or voluntary agency in the counties of Maryland which has any legal responsibility for organizing medical care for the indigent and the medically indigent. In many states this is not the case. As a result, in Maryland, while many agencies are doing what they can through local agreement and friendly cooperation, the large majority deplore the existing confusion. This holds true of the medical, dental and nursing profession, the State Department of Health, the State Department of Welfare, the county commissioners and the voluntary health agencies. The confusion is illustrated by the fact that in most counties when an indigent patient is taken ill, he will apply indiscriminately for help to the nearest physician, the county health officer, a public health nurse, a welfare worker or the office of the county welfare department, or to the county commissioners. Medical services are arranged for, if they are obtainable, by any expedient that will meet the situation, usually by personal requests to a neighboring physician to give free service, rather than in accordance with a definite plan or agreement.

It has been observed by the Executive Committee that there is a widespread and increasing demand that some program be evolved to meet these needs, and to correlate the work of existing agencies.

Essential Features in a Long Term Program for Medical Care in the Counties

In any long term program for medical care in the counties of Maryland the following features, in the opinion of the Committee, are essential:

1. *That adequate medical care be ensured to all, and that the normal flow of physicians into these areas be maintained to replace those whom age, disability or death have removed from active practice.*

In recent years many programs for medical care of the indigent among the population are being carried out in various sections of this country and in Canada. The chief feature in the majority of these plans has been the assumption by the government of the responsibility of paying for certain types of medical care furnished to the indigent by physicians of the community. Such programs meet one great need, that of enabling communities which can no longer support a physician, to retain his services by furnishing him with an income for his work among the indigent. If there are sufficient physicians, the amount of medical care of certain types will be adequate. It is apparent to the Committee on Medical Care, however, that such programs have not touched many fundamental problems associated with medical care in rural districts. Emergency medical care may thus be provided, but the *quality* of medical care will not be significantly affected. To insure a satisfactory level of medical care for a term of years in a rural area, it is fundamental that there be a normal flow of physicians into that area to replace those whom age, disability or death have removed from active practice.

2. *That local facilities for a modern type of medical practice be provided.*

The question of assuring a renewal of supply of physicians is intimately bound up with the question of enabling the local physicians to carry on a type of practice which is abreast of modern developments in medicine. A young physician considering a county practice will ask himself, not only whether he can earn a living in the county, but whether he will be able to utilize the skills he has acquired during his years of study and hospital training. As new developments in medicine occur, he will also be concerned as to whether he will be in position to learn of them and apply them in his practice, or whether he must find himself steadily retrogressing.

Any program, therefore, which is to ensure adequate medical care for a long period, must include the provision of local facilities for a modern type of medical practice, and also a solution of the problem of providing such contacts between the local physician and the medical centers, as will enable the physician to give to his patients the advantages of the progressive advances in medicine.

3. *That such local facilities should include, among other essentials, certain types of laboratory and Roentgenological services.*

Elsewhere in this report are cited certain studies on the distribution of physicians, which indicate that young doctors are not entering the less prosperous areas in sufficient numbers, with a consequent impairment of medical services in rural areas.

In connection with making diagnostic facilities available to the practicing physician, it should be pointed out that, even if it were possible for each physician individually to equip himself completely with such facilities, it would be highly uneconomical and his patients would have to pay in the long run for this economic fallacy. Certain types of laboratory and Roentgenological services requiring expen-

sive primary outlays for equipment and trained personnel for their employment, are most economically used if they serve a considerable group of physicians or where there is an adequate clientele for their use.

The State Department of Health has made considerable progress toward enabling county physicians to obtain such services. Its experience indicates that it is advisable that certain diagnostic tests be performed at branch laboratories, whereas others are sent in from all over the State to the central laboratory, where mass production methods enable them to be performed most efficiently and economically. An experiment initiated by the Committee on Medical Care and now in progress, involving a group of three county hospitals, has for its objectives the determination of how the State Department of Health branch laboratories may cooperate most efficiently and economically with local laboratories. It is hoped that by this arrangement the local laboratories will be enabled to give adequate laboratory services for the indigent under treatment in the clinics of the county health department, and that the branch laboratories of the State Department of Health will enable the local hospitals to maintain more efficient laboratories at less cost by furnishing them with consultant and supervisory personnel, and making available to them the resources of the State laboratories for tests which otherwise could not be performed.

Further developments in this direction are certainly attainable if interest is focused on the objective of obtaining for the practicing county physicians a maximum of diagnostic facilities by the most efficient and economic methods.

4. *That, in the interest of lowering the cost of medical care, serious efforts should be made to improve home care through home nursing, laboratory service and other facilities.*

Modern medical practice requires the utilization of the hospital for the care of patients with certain types of illness, or for the correction of certain handicapping physical conditions. Economy demands, however, that the patient should not be treated in hospitals unless the hospital has positive benefits to offer, which cannot be adequately supplied in the home. It appears to be quite feasible to improve home care through home nursing services, laboratory service, and other facilities. There can be little doubt that the introduction of such services would influence the cost of illness. When adequate treatment can be given at lower cost than in the hospital, patients should be kept at home. Moreover, since hospitals vary in size and type of equipment, the hospital to which the patient is taken should be the nearest one which can adequately and economically furnish treatment for his case.

5. *That arrangements be effected for improving the flow to the larger, well equipped medical centers of those seriously ill patients requiring highly specialized and expensive diagnostic procedures and treatment.*

A small rural hospital has a very important role to play in the community. It can save lives by furnishing near at hand emergency care in surgical and medical emergencies in which time is of great importance. It can furnish obstetrical care, medical care for many serious illnesses as well as a wide variety of types of surgery.

On the other hand, there are diagnostic procedures, serious types of operations, and other therapeutic measures which are beyond the scope of the small rural hospital. Some of these conditions may well be handled in the larger hospitals in small cities; others may require all the resources available in the medical centers of a large city. Small rural hospitals have sometimes lost the confidence of their communities by permitting members of their staff to attempt procedures for which adequate experience and equipment were lacking. The transfer of complicated cases to the larger medical centers is at the present time hampered by transportation difficulties, lack of knowledge on the part of the physician of city medical resources, and by difficulties connected with the payment for hospitalization of indigent county patients. Moreover, in many instances when patients return to the counties no adequate record of what was done in the city, or what further treatment was advised, is made available. The better organization of this whole aspect of rural medical care is an important part of any future program.

6. *That the local hospital should be more adequately supported and equipped.*

Supported by adequate equipment and by consultant services, the local hospital will, in the performance of its natural function, greatly aid the young physician by enabling him to utilize his intensive training, and by making it possible for him to put into practice newer developments in the field of medicine.

At present, many of the smaller rural hospitals in Maryland have a low percentage of occupancy. This seems explainable in part by the fact that many of them lack the equipment and the personnel for certain categories of work which should naturally be included within their scope. Meanwhile, patients from these areas are compelled to make expensive trips to distant centers and the local physicians lose the opportunity of treating them. Such circumstances not only increase the cost of medical care to the citizens of the county, but an opportunity for raising the community level of medical care is lost. Moreover, it discourages young, ambitious physicians from establishing themselves in such a community.

7. *That a definite coordinated State-wide clinic program be adopted.*

The clinics for special types of disease which are operated at regular intervals in all of the counties of Maryland under the supervision of the State Board of Health, the Maryland Tuberculosis Association, the Maryland League for Crippled Children, and a number of other agencies, constitute an important element in medical care in the counties. Not only do they enable many indigent cases to receive specialized care which they would not otherwise obtain, but through the visits of consultants, they give to local physicians, who in many instances staff the clinics, a contact with newer methods of diagnosis and treatment. The clinic program, however, has developed rapidly, apparently with expediency as the guiding principle rather than systematic planning. In some instances local antagonism has been aroused, in others the educational value of the clinics to the local physicians has not been developed. Both the medical profession and the State Department of Health feel that this valuable adjunct in the field of medical care of the indigent would be strengthened if a definite program could be adopted in the formation and administration of which the medical profession, the State Department of Health and the State Department of Public Welfare had a voice.

Summary

A program of medical care in the counties of Maryland must involve a series of definite agreements between the practicing physicians, the State Department of Health, the State Department of Public Welfare, the voluntary health agencies, local and State-wide, and the county commissioners as to what part each shall play and as to what classes of cases shall be served by different aspects of the program.

The program must include medical care in the home, in the physician's office, in clinics and also in general and special hospitals within and outside the county, according to available facilities and the nature of the patient's condition.

A continuing program must be such as to ensure a constant renewal of the supply of physicians, and of other professional personnel. It must be based upon a recognition of the fact that such personnel will move into rural areas only when they offer a reasonable financial return for professional work, adequate diagnostic and therapeutic facilities, especially in the form of well equipped local hospitals, and some feasible method by which the physicians can maintain contact with new developments in medicine.

In any long term program for medical care in the counties the following are essential features:

1. That adequate medical care be ensured to all, and that the normal flow of physicians into these areas be maintained to replace those whom age, disability or death have removed from active practice.
2. That local facilities for a modern type of medical practice be provided.
3. That such facilities should include, among other essentials, certain types of Roentgenological service.
4. That in the interest of lowering the cost of medical care, serious efforts should be made to improve home care through home nursing, laboratory service and other facilities.
5. That arrangements be effected for improving the flow to the larger, well equipped medical centers of those seriously ill patients who require highly specialized and expensive diagnostic procedures and treatment.
6. That the local hospital should be adequately supported and equipped.
7. That a definite coordinated State-wide clinic program be adopted.

Chapter XII

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Although Maryland is fortunate in her wealth of medical facilities and the general high level of medical care received by her citizens, and although the profession, on a voluntary basis, has unselfishly and untiringly given medical care to the indigent, the following important observations have been made:

1. In some sections of the State certain essential medical services are not available to the indigent and medically indigent.

2. For many years the State and county health departments, in collaboration with the State and county medical societies, have furnished diagnostic and, in some cases, therapeutic services in tuberculosis, venereal disease, orthopedics and mental disease.

3. There has been a growing tendency for the indigent and medically indigent to request and receive medical care from State and county health departments.

4. Except in the limited fields of medicine with which the State and county health departments are now concerned, there is at present no State or other agency legally responsible for providing medical care for those unable to pay for these services, and there is no clearly defined procedure by which such care may be obtained.

   The indigent sick may usually secure, without cost, a visit from a neighboring physician. As a rule, however, for cases of chronic disease, for those requiring intensive diagnostic study, and for persons needing hospitalization, medical care is available only when some individual or agency intervenes on behalf of the patient and secures the necessary service as a matter of charity.

Recommendations

The Committee on Medical Care presents the following recommendations:

1. That a program providing medical care for the indigent and medically indigent in the counties be established by the State of Maryland.

2. That this program be formulated and administered by the State Department of Health which shall be held responsible for the compensation of physicians and of institutions for services rendered to eligible persons. Should Federal legislation provide otherwise, it is assumed that this recommendation might be modified.

3. That the State Department of Public Welfare shall have no responsibility for providing medical care but shall determine the financial eligibility of applicants.

4. That specific appropriations adequate to finance this program should be made by the State of Maryland to the State Department of Health and to the State Department of Public Welfare.

   (a) Appropriations to the State Department of Health should provide for payments to physicians, hospitals and county health departments for services to the indigent and medically indigent; for salaries and expenses involved in the administration of the program; for the purchase of equipment, supplies, drugs and biologicals; and for the provision of additional space necessary for the proper conduct of these services.

   (b) Appropriations to the State Department of Public Welfare should be adequate to provide for the discharge of the duties of this agency under the program.

Course of Action Recommended

To implement these recommendations, the following procedures are advocated:

1. The State Board of Health should be authorized to establish a Council on Medical Care which shall act in an advisory capacity constituted as follows:

   Two members appointed by the Council of the Medical and Chirurgical Faculty of Maryland.

   Two members appointed by the State Board of Health, one of whom must be the Director of the State Department of Health.

   One member from the Faculty of the Medical School of Johns Hopkins University, and one from the Faculty of the Medical School of the University of Maryland, to be appointed by the governing body of the respective Medical Schools.

   One Maryland hospital administrator appointed by the Maryland-District of Columbia Hospital Association.

The Director of the State Department of Welfare.

One dentist appointed by the governing body of the Maryland Dental Association.

One nurse, appointed by the Board of Directors of Maryland State Nurses Association.

The Commissioner of Mental Hygiene.

The superintendent of the tuberculosis sanatoria of Maryland.

One member appointed by the Executive Board of the Maryland Medical Association.

2. In the interest of economy and efficiency, the Council on Medical Care should seek to integrate the many agencies of the State Government which are now concerned with medical care.

   The organizations which should be included and the manner in which they should be combined to effect greatest economy should be the subjects of further study.

3. With the advice of the Council of the Medical and Chirurgical Faculty of Maryland and of the Maryland State Dental Association, the Council on Medical Care should recommend to the State Board of Health the appointment of medical and dental consultants who shall, when requested by local physicians or dentists, through appropriate channels, perform the duties outlined elsewhere in this report.

4. A Bureau of Medical Care should be established within the State Department of Health for the administration of the program. The Chief of this Bureau should be a physician who is experienced in the organization and distribution of medical care, and who serves on a full-time basis. This physician should be appointed by the Director of the State Department of Health and serve under his supervision.

5. In cooperation with the county medical societies, the county health officers shall administer the local aspects of medical care program.

6. Other phases and details of this program should, so far as practicable, follow the suggestions embodied in the text of this report.

The Need for a Separate Study for Baltimore City is Indicated

Although less urgent, it is recognized that a program to accomplish similar results must be developed for the City of Baltimore. Because of the differing problems, however, the Committee on Medical Care considers that the formulation of such a program for Baltimore City should be the subject of a separate inquiry and report.

Hospitals for Treatment of Chronic Disease

Shortly after the Committee began its survey, Governor Herbert R. O'Conor appointed a Commission to consider the advisability of establishing special institutional facilities for the care of the chronically ill. The Committee on Medical Care did not, therefore, feel justified in recommending any specific solution to this problem. It wishes to record, however, that all of the information assembled by its survey indicates an urgent need for such facilities, and in the discussions of the Committee with the medical profession, health and welfare department workers, and others concerned with the care of the sick, the immediate establishment of adequate facilities for the care of the chronically ill was considered by them to be of vital importance. The Committee urges, therefore, that the plans for the establishment of chronic hospitals be consummated at the earliest possible date.

APPENDIX

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Medical and Chirurgical Faculty
of the State of Maryland.
1211 Cathedral Street.
Baltimore.

August 23, 1939

Mr. Abel Wolman, Chairman
State Planning Commission
Baltimore, Maryland

Dear Sir:

The Medical and Chirurgical Faculty of Maryland desires to draw your attention to the advantages of constituting a new Section or Standing Committee of the State Planning Commission whose function it shall be to keep under constant survey the problems of medical care for the citizens of this State and to formulate from time to time recommendations for better utilization and for extension of existing medical facilities and for the institution of such new facilities as are required.

We are using the term "medical care" in an inclusive sense to cover all the agencies available in safeguarding and improving the health of the people and in the treatment of disease. It may be interpreted therefore as comprising lay and professional medical education, sanitation, preventive medicine, curative medicine, dental and nursing care, and pharmacy. It is evident that there exist today, and, in view of the rapid advances in medical science, that there will always exist difficulties in making available to all the highest standard of medical care. It would be the function of such a committee as we propose to be constantly comparing what is available in the way of medical care in our State with what is known to be valuable and to plan systematically to repair the deficiencies in our present system.

Though Maryland is fortunate as compared to the majority of States in her wealth of medical facilities and in the average high level of medical care which her citizens receive, yet this Committee will quickly become aware of many urgent needs for improvement.

Among the deficiencies in the present system of medical care in Maryland the following may be cited as outstanding examples:

(1) Lack of facilities for hospital care for Negro patients in the counties.

(2) The lack of adequate support for the out-patient departments of city and county hospitals.

(3) The lack of funds or organization for the medical care in their homes of those upon relief and for other classes of indigent patients.

(4) The lack of facilities for postgraduate education for practicing physicians.

(5) The inadequate buildings, equipment, and budget of certain county hospitals.

(6) The lack of beds in the counties for the care of chronically disabled patients.

(7) The lack of adequate accommodations for existing institutions for the feeble-minded, especially among the colored race.

These urgent needs are cited merely as instances of some of the problems which demand solution.

The needs just cited are well known to our Welfare Boards, to our Boards of Health, to this Faculty, and, in general, to social service workers, physicians, nurses and all those who devote themselves to the medical care of the population. Efforts have been made by all of these agencies to obtain improvements. There has, however, never existed an official warrant for any group to evolve a coordinated program in which all health agencies would play a part. The problems require such a cooperative effort for their solution and it is the opinion of this Faculty that only through the efforts of a Committee with official standing and in the membership of which the various health agencies are represented can such a cooperative program be achieved.

The existing system of medical care is composed of many interrelated elements. It derives its support from the fees of private patients, from the philanthropic contributions of the general public to medical institutions, from the philanthropic donations of service by the medical profession and from tax funds devoted to public health and to the support of medical institutions.

There is general agreement that an increase of the financial support derived from tax funds is a requisite to adequate development of medical care. It is vital, however, that the program for such State-supported improvements in our present system of medical care be devised so as to conserve all of the valuable assets we now possess and not be planned in a manner which would set one form of medical service in competition with another to their mutual disadvantage.

Only a Committee which includes representatives from the agencies best acquainted with the different aspects of the present system of medical care can wisely devise a program for the most efficient development of this system. Further, it seems desirable that such representatives of the various health agencies should be selected from a list of nominees furnished by each agency, since the executive body of each agency is best acquainted with the special qualifications of its members. Moreover, since the public is to be on the one hand the chief beneficiary of improved medical care and on the other hand the chief source of financial support it seems evident that there should be lay representation.

Upon the basis of these principles the Faculty suggests the following tentative composition of the proposed Committee:

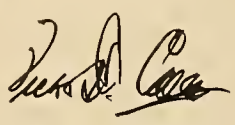
The State Welfare Board	1 member
The Baltimore City Welfare Board	1 member
The Maryland State Board of Health	1 member
The Baltimore City Health Department	1 member
The Medical and Chirurgical Faculty	1 member
The Baltimore City Medical Society	1 member
The Maryland Medical, Dental and Pharmaceutical Association (Colored)	1 member
The Maryland Dental Association	1 member
The Maryland Mental Hygiene Society	1 member
The Maryland Tuberculosis Association	1 member
The Maryland State Nursing Association	1 member
The Baltimore Hospital Conference	1 member
The Maryland Conference of Social Welfare	1 member
The Maryland Pharmaceutical Association	1 member
The University of Maryland Medical School	1 member
The Johns Hopkins Medical School	1 member
The Johns Hopkins University School of Hygiene and Public Health	1 member
From the lay community	3 members

This list does not represent all aspects of medical care, but in the interest of compactness has been selected to cover the chief categories.

It is evident that to work effectively such a Committee must have a salaried Executive Secretary and stenographic assistance. The funds for such services will have to be sought from the public, from the State or from the participating agencies. The Medical and Chirurgical Faculty has no funds available, but as a token of its sincere desire to forward the formation of this Committee, members of its Council will pledge themselves to raise the sum of five hundred dollars yearly for three years, by private subscription from the membership, to be applied to the expenses of the Committee.

We trust that as Chairman of the Maryland Planning Commission you will give careful consideration to the advantages of forming such a Committee on Medical Care and will recommend to the Governor the steps towards its organization.

Very sincerely yours,



Victor F. Cullen,
Acting President, The Medical and Chirurgical Faculty of Maryland.